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Abstract

This thesis explores the complex nature of the policy process through the actions and intentions of the multiplicity of national and local actors involved in the development, through implementation, of a particular initiative: direct payments for community care. The methodology combines both 'top down' and 'bottom up' perspectives on policy-action (Sabatier, 1986) in a case study, using documents, personal accounts and observations.

The case study follows New Labour's efforts to secure policy effectiveness while delegating the responsibility for implementation to local councils. The research focused primarily on one authority. It took place within the context of that authority's efforts to 'modernise' community care through pragmatism, partnership, participation and centralised performance management. The findings are compared to experiences in another authority, thereby combining the validity of Pawson and Tilley's (1997) assertion that the outcomes of the ideas and opportunities offered by policy initiatives vary with context. This comparison illustrates the influence of contextual features on policy outcomes: local politics, history, culture and the community's expectations and experiences of policy developments.

In the 'policy-action' relationship examined, ultimate objectives and the means of achieving them were re-defined and prioritised through negotiation and experience, as parts of New Labour's own discourse were appropriated (Newman, 2001). The relevance of Lindblom's (1959) classic 'muddling through' account of the process is thus revealed, along with the contribution of 'street level bureaucrats' in interaction with citizens (Lipsky, 1980), to policy development through implementation. The influences of values and convictions, as well as personal experience and interests, on the agency of policy actors are highlighted.

The thesis concludes that central government will only achieve the objective of 'promoting independence', through initiatives intended to extend choice and control to most service users, when and where it engages and empowers people at the level of citizen-practitioner interaction.

**Politics, Practitioners and People : Direct payments for
Community Care, a Case Study in Policy Implementation**

Michaela Griffin

Submitted for the degree of PhD

University of Durham

2003

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13 JUL 2004

Dedicated to Dot and Steve who taught me Right from Left

Thanks

To Professor John Carpenter and Dr Nick Ellison for their patience and perseverance;

To the good people of 'Fletcherford ' and Bigtown', and all the policy makers and practitioners for giving their time and sharing their knowledge and experience;

To the research staff and students in C.A.S.S. for practical help, sensible advice and the loan of offices and equipment;

To Claire Dickinson, who did not need to practice to be a social worker;

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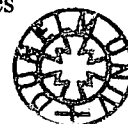
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Introduction and Overview

'The problems of policy implementation therefore demand attention for good academic and practical reasons; a government dedicated to radical action on its own distinctive interpretation of the 'policy failure' of recent decades offers an opportunity for such research' (Webb and Wistow 1982 , 17)

This thesis explores the complex nature of the policy process through a case study of the extension of 'direct payments' for community care, a project that formed part of the Blair Government's plan for '*modernising*' social services. Direct payments were chosen because they feature a cluster of characteristics common to the 'New' Labour government's '*modernising*' initiatives (Dept of Health 1998a) and thus meet the criteria of a 'typical' case as proposed by Bryman (1988). The case study demonstrates how social policy is made and developed by actors at every stage in the implementation process, from national and local politicians to individual practitioners and citizen/ service users. It also illustrates that irrespective of central government's intentions to impose particular theories of social policy effectiveness on policy actors, individuals at every level act on the basis of their own values and beliefs about the means and ends of social policy, alongside their personal interests. In the complex policy action process however, outcomes depend on context and contingency as well as policy theories and ideology.

The policy studies literature has traditionally questioned how far 'policies' are made and developed by those with authority from and accountability to the electorate, as well as the contribution of ideological convictions and social theories about the relationship between the means and ends of policy. The concept of the 'implementation gap' was used by Dunsire (1976) to describe the problems policy makers have in achieving their intended outcomes. The particular difficulties experienced in distinguishing policy making from implementation, when implementation responsibilities are delegated by one tier of government to another were highlighted by Hill (1981). These were illustrated by more recent research by Pearson (2000) on the example used in this thesis. She found that alternative discourses dominated in a Labour and a Conservative council and influenced the way that direct payments developed in each area, with a consequent impact on outcomes. Assumptions that central decision- makers are the key actors in the policy process therefore have long been challenged (Hjern 1982), along with the understanding that progress in implementation follows logically and sequentially from a policy decision (Lindblom 1959, Schwandt 1997). The contributions of non-elected actors have been identified, whether senior public servants (Niskansen 1973, Tulloch 1976, Dunleavy 1986), agency managers (Meier and Mc Farlane 1996), interest groups (Maloney and colleagues 1994) or welfare practitioners (Lipsky 1980). A synthesis of 'top down' and 'bottom up' approaches to policy implementation research was recommended by Sabatier (1986). The top down approach begins with a policy decision and focuses on the extent to which its objectives are achieved over time. The bottom up approach begins by identifying the network of actors and agencies



involved in policy formulation and implementation. The synthesis combines the *top downer's* concern, about the ways in which socio-economic conditions and legal instruments constrain behaviour, with the *bottom upper's* interest in understanding the perspectives and strategies of the public and private actors involved with a policy problem.

In the example of direct payments for community care, the literature highlights the role of the disability rights movement in policy development at both the national and local level.

Organisations run by disabled people¹ first persuaded some councils (Oliver and Barnes 1998), and then government (Dept of Health 1997), of the potential of direct payments as a means of increasing the choice, control and independence of service users and the cost effective use of resources (Brandon 2002, Campbell and Oliver 1996, Hasler 1999, Holman 1999, Morris 1997, Priestley 1999, Zarb and Nadash 1994). Participation by individual service users however, in the implementation of Conservative governments' community care policy generally, fell short of the democratic ideal promoted by Beresford and Croft (1993) and Arnstein (1971). Instead, Shaw (1997) suggested that the involvement of users was often restricted to the 'micro-level' of individual influence on the actions of front line workers with little impact on policy or decision-making.

The New Labour government was critical of the Conservative party's approach to the implementation of 'community care', apparently recognising the 'implementation gap' between policy aims and outcomes. It blamed its predecessors' failure to realise this policy's intentions on lack of clear central direction, lack of consistency in objectives and lack of involvement of service users/ citizens (Dept. of Health 1998a). The past performance of social services departments was discussed in policy documents and political speeches within a '*discourse of failure*' (Clarke and colleagues 2000). Four strands to the alternative approach promised by Blair's party in government can be discerned in policy statements and documents:

- 1) 'Third way' pragmatism, policy action based on 'what works' rather than ideological commitment to either state provision or to market devices;
- 2) 'Joined -up' thinking and action in policy making and implementation;
- 3) Participation of citizens and service users in decision-making on the planning, development and delivery of services;
- 4) Centralised performance management, making clear to policy actors what is expected of them and requiring them to account for their performance in pursuit of government objectives.

¹ The term 'disabled people' derives from the social model of disability and is used generically when distinctions are not drawn between the source of particular impairments, so includes learning difficulties, frailty with age and mental health problems. However Shakespeare (1993,1994) and Morris (1993) argued that the nature of impairment is ignored at the risk of denying the reality of a significant aspect of human experience.

New Labour's approach to social policy works within, and contributes to, the renewal of civil society and responsible citizenry, according to Blair (1996, 2001a) and Giddens (1998), or as Newman (2001, 6) suggested:

'The languages of democracy, citizenship, society, community, social inclusion, partnership and public participation, central to new Labour's discursive repertoire, can be understood as an attempt to reinstall the "social" in public and social policy.'

Policy action is examined in this study, as already explained, through the example of a particular initiative within the wider policy programme of the New Labour government. It demonstrates how both 'top down' and 'bottom up' theories and alternative philosophical and ideological models of social policy can contribute to our understanding of what happens in the implementation process. Central government policy initiatives may begin at 'the bottom' and be influenced by the interests and actions of citizens and their organisations. In the case study, legislation responded to the campaigning efforts of the disability rights movement and research that demonstrated the success of 'third party' direct payment schemes, developed by some local authorities in partnership with voluntary organisations. Policy continued to develop during implementation shaped by the actions, interpretations and aspirations of individuals and groups; these included local politicians, public service managers and professionals and those directly involved in the service delivery process, both practitioners and citizens who use their services. In the 'policy-action' relationship examined, the ultimate objectives and the means of achieving them were re-defined and prioritised through negotiation and experience, as a continuing process. This study thus confirms the continuing relevance of Lindblom's (1959) 'muddling through' account of policy action. As Lindblom and Woodhouse (1993, 68) later described: *'...policy evolves through complex and reciprocal relations among all the bureaucrats, elected functionaries, representatives of interest groups, and other participants.'*

The research for this thesis focused primarily on implementation within a single local authority here called 'Fletcherford'. It took place within the context of the authority's efforts to 'modernise' through the promotion of the 'third way' for social care. It also drew on experiences of actors engaged in similar implementation processes in another local authority 'Bigtown', also led by the party in government. The study therefore focuses on areas (Northern Labour councils) and organisations (social services departments) traditionally perceived as sympathetic to 'Labour' policies and values. It moves on from earlier research that contrasted alternative approaches of Conservative and Labour run councils to community care implementation and direct payments (Priestley 1999, Pearson 2000).

Chapter one begins the case study by exploring the social policy theories, ideas and intentions of the national policy-makers responsible for public service reform and the extension of direct

payments. The debate about New Labour's contribution to social policy, in offering a pragmatic alternative to an ideological domination by either the public sector or the market, is discussed. The policy statements and initiatives of the Blair government are explored in this context. The chapter concludes with a review of the various critiques of the recent development of British social policy, using the framework of the key questions proposed by Driver and Martell (1998).

Chapter two examines New Labour's approach to policy effectiveness through the particular initiative. The history of direct payments is outlined and the implications for implementation discussed. The characteristics that make the extension of direct payments typical of a 'third way' initiative are explained, in order to establish the appropriateness of the policy example for a case study.

Chapter three reviews the literature on policy implementation and discusses its relevance to direct payments and community care. The research revealing the gaps between the intentions and outcomes of community care policy and the tensions in the roles of practitioners as 'care managers' is explored. The weaknesses of the community care market, as an efficient means of allocating resources, are examined in relation to economic theory and the research of Le Grand and Bartlett (1993) and Bartlett and colleagues (1998) amongst others. The concept of '*street level bureaucracy*' theorised by Lipsky (1980) is introduced: in Lipsky's analysis, welfare practitioners completed the policy making process in interaction with citizens/ service users. The implications of these findings for the implementation of direct payments and New Labour's wider policy programme are considered and the research questions are introduced.

Chapter four explains the methodology of the case study and the methods used to address the research questions. The methodology is informed by the work of Pawson and Tilley (1997) who advised that policy research needs to be theory rather than method driven. The 'programme' studied should not be treated as a 'black box'. The researcher should not simply identify 'what works', but attempt to uncover how a policy initiative works:

'...programmes work (have successful 'outcomes') only in so far as they introduce the appropriate ideas and opportunities ('mechanisms') to groups in the appropriate social and cultural conditions ('contexts').' Pawson and Tilley (1997, 57)

The research findings are presented in the following five chapters. Three 'elements' of the policy action relationship were distinguished by Barret and Fudge (1981,7): the environmental system from which demand arises; the political system in which decisions are made and the organisational system through which policy is mediated and executed. Each element is explored through the case study example. Chapter five is an account of the events that led to the decision to introduce direct payments by Fletcherford council, after they were promoted by the Blair government. It includes data from interviews with actors involved at the national and local level and policy documents, reports and records. Fletcherford was one of the last nine councils in

England to introduce direct payments in 2001, having 'rejected' them as a Conservative government initiative, following a consultation with the local community in 1997. The importance of the political, historical and social context to actors' perceptions of and responses to policy change is revealed. This account begins to illustrate how public servants and citizens contribute to the development of social policy.

Chapter six presents data from a survey of practitioners' opinions and expectations of direct payments, early in the local implementation process, and an analysis of their implications. Practitioners' own explanations of their experiences of community care implementation are discussed with reference to the literature. The survey findings reveal that at the beginning of the study, in 2000, practitioners were generally in favour of the principle of introducing direct payments and supported the Blair government's policy programme. They were also able to identify potential obstacles to the success of the initiative in the local context.

Chapter seven gives an account of the planning process for the introduction of direct payments in Fletcherford, based on observations, records of meetings and interviews with the actors involved. The council's interpretation of the Blair government's advice to involve disabled people in the development of local schemes and the implications of this approach are analysed. Despite the government's efforts to improve policy effectiveness through promoting participation in decision-making, this chapter shows how community and user representatives were marginalised. More powerful actors were able to divert the local planning process to alternative ends. Other aspects of the government's approach to policy effectiveness, in particular centralised performance management, also proved to be counter-productive.

Chapter eight discusses the motivation and experiences of those involved, at the 'street level' of citizen-practitioner interactions, contrasting the potential of the initiative with its performance in the particular context of Fletcherford. The role of care managers, in interpreting and developing policy through their relationships with individual service users, is illustrated. It demonstrates that community care 'consumers' were not simply motivated by the instrumental rationality, on which classical market theory (Smith 1961) and policy initiatives that draw on its principles (Dept. of Health 1998a, Dept. of Health 2000a) are based. They were concerned also with issues of social justice. Opportunities to benefit from greater 'choice', however, were not equally distributed.

Chapter nine presents data from interviews carried out in 'Bigtown'. It identifies and attempts to explain the similarities and differences in experiences in the two 'Labour' areas, with reference to the relevant literature. It illustrates that even within policy environments broadly supportive of central government intentions, the values, perceptions and social policy 'theories' of

individual actors can interact with the political, historical and social context to unintended effect.

Chapter ten discusses the contribution of the case study with reference to the literature. The framework provided by Pawson and Tilley (1997) is used to analyse the outcomes of the interactions between 'contexts' and 'mechanisms' in policy action in the two authorities. The conclusions support the thesis that the outcomes of particular policy initiatives depend on the interactions of the ideas and opportunities they introduce with the political, historical and social conditions in particular contexts.

CHAPTER ONE

New Labour's Social Policy : Modern Means to Traditional Ends?

'There is a clear road map to our destination but sometimes it can seem as if it were a mere technocratic exercise , well or less well managed, but with no over-riding moral purpose to it. ' (Blair 2002b,4)

1.0 Introduction

The context for a study of the policy process through the example of a particular initiative, the extension of direct payments by the New Labour government (Dept. of Health 2000a) is presented in this chapter. Direct payments are cash sums given to individuals by local authority social services departments, in lieu of community care services. They give people in need of social care both the resources and the responsibility to arrange their own services in the independent sector.

The party led by Tony Blair claimed to have made a distinctive contribution to the achievement of social policy objectives, in offering an alternative to an ideological domination by either the public sector or the market. Here, the policy statements and initiatives of the Blair government are explored alongside the debate in the literature about the meaning and implications of New Labour's approach. Consideration is given to Driver and Martell's (1998) thesis that Blair's government was ideologically 'post -Thatcherist' alongside Powell's (1999) argument that it was essentially pragmatic. This chapter concludes with an examination of New Labour's programme of welfare reform using Driver and Martell's (1998) framework to address 'Who, Why and How?' questions about the development of social policy, with particular reference to direct payments.

1.1 The Vision

Blair's speeches and his government's policy documents revealed three overarching themes: ethics (rights and responsibilities), economic efficiency and social cohesion. These were inextricably linked; the achievement of each depending on the achievement of all. They provided the context for New Labour's policy programme within which particular initiatives can be considered.

'The reform programme to improve public services is every bit as crucial to the future of Britain as changing Clause IV was to the future of the Labour Party.' (Blair 2001a, 6)

In an early speech as party leader Blair (1994) reasserted what he called 'ethical socialism', as a set of values and beliefs. He distinguished ethical from 'Marxist socialism', which was based on notions of economic determinism and a particular view of class. 'Marxist socialism' is dead because it misunderstood the nature of the development of a modern market economy *'it failed*

to recognise that the state and the public sector can become a vested interest capable of oppression as much as the vested interests of wealth and capital..' (3). Blair's project was as much about establishing new political ideas and representations of society as it was about new policies, institutions and practices, in Newman's (2001) analysis of New Labour's attempt to establish its own dominant narrative.

Blair's critique of what Rouse and Smith (1999) call the 'public administration paradigm' would have found support in the 1970s, from across the political spectrum. However it was the New Right's analysis of the rigidities of public sector bureaucracies that gained ascendancy following the election of the Thatcher government in 1979. The basis of the ethical 'social-ism' reasserted by Blair (sic) was that individuals are socially interdependent. It is only through recognition of that interdependence that the collective power of all can be used for the good of each; '*..it takes an enlightened view of self-interest and regards it, broadly, as inextricably linked to the interests of society..*' (Blair 1994, 4) This seemed a stark contrast to Thatcher's (1987) statement that there is no such thing as society, only individuals and families. Public Choice theorists associated with the 'New Right' drew on classical economic theory that predicted that by each person pursuing his self-interest in a free market, the welfare of all would be maximised and the optimum allocation of resources achieved (Smith 1961). In the above interview, Thatcher also observed that there can be no entitlement without obligation. Novak (1998, 2) asserted that the Thatcher government's reforms provided a foundation on which the Blair government has been able to build:

'By launching Great Britain on a trajectory of growth and opportunity ... the Iron Lady weaned New Labour from a sterile and punitive redistributionism, on the one hand, and from the enervating Nanny State on the other.'

The call from Novak for the renewal of civil society and individual, responsible citizenry through the devolution of power from state bureaucracies to citizens elicited a response from Giddens (1998b). He observed that 'Thatcherism' was '*the enemy of devolution*' draining power from the local to the central state. There is a distinction between the citizen as consumer, consulted about and expected to take greater responsibility for decisions that affect his or her life in the private sphere and the citizen exercising power in the public sphere. This distinction will be discussed further in the context of direct payments for community- care.

1.1.1. Citizenship and New Labour

One question raised by the literature is, does New Labour's social policy simply enhance the role of the user as consumer in a market for services, developed in the Conservative governments' public sector 'reforms'? Alternatively, does the concept of the user as citizen mean more with New Labour than extending purchasing power, choices and 'participation' through limited consultation as a form of market research (Hunter 2001).

Citizenship is a fundamentally contested concept. Two traditions in the understanding of citizenship are identified by Dean (1999). The individual model is rooted in classical liberal theory, which understands citizenship as a contractual relationship between the individual and the state. The social model is based on the classical ideal of 'civic republicanism', which subordinates the sovereignty of the state to solidarity and the need for social integration and cohesion. The New Right's critique of social policy, and the changes it inspired in Britain in the 1980s and 90s, were based on the individual/ contractarian model and in some respects represented an attempt to 'privatise' citizenship. Welfare transactions were perceived as akin to market contracts. The 'consumerist' approach found some expression in the policy realm of community care during the Major administration and service users were given 'consumer rights' through the 'Citizen's Charter' (Prime Minister's Office 1991). Users were given the right to be consulted on decisions but not to veto or contribute directly to decision-making. They were given the right to choose between the state and independent sector provision but not to participate in the development of services or in the processes of establishing priorities and allocating resources. Users were given the right to complain when the promised standards were not met, but not to have a direct role in setting those standards. Cowen (1998) maintained that New Right advocates of individual consumer rights rewrote discourses on citizenship.

Another slant on the consumerism/ empowerment debate was discernible in the work of Gilliat and colleagues (2000). They argued that the concept of the 'responsible consumer' has emerged in public sector managerial consciousness. There has been a shift in the balance between what is normal for services managers to do and what it is expected users should do for themselves. Organisations achieve more flexibility as users increasingly share responsibility for rationing scarce resources. Consequently it is the producer rather than the consumer that is empowered. This analysis is relevant to the debate on the development of direct payments that gave service users responsibilities for managing individual community care budget allocations.

Major's contribution did not resolve the tensions inherent in Thatcherism, an orthodoxy that simultaneously promoted both a free market economy and a strong central state.

'Major's Citizen's Charter was –and still is- a much mocked policy. But it recognised- and by recognising exacerbated- the conflict between individual rights and collective provision.' (Timmins 2001, 5).

Alongside the promotion of 'active citizenship' intended to free people to give voluntarily to those worse off, the social security system has become more coercive and punitive to some 'users', the unemployed and single parents (DSS1998). This apparent concern with promoting responsible behaviour was shared by the Conservative and New Labour governments. Dean (1999) suggested that New Labour's revised 'clause 4' drew on contradictory notions of citizenship, in the commitment to the creation of a community: '*...where the rights we enjoy*

reflect the duties we owe, and where we live together freely, in a spirit of solidarity, tolerance and respect' (Labour Party, 1995).

The 'new contract between citizen and state' (DSS 1998) made rights to collective support conditional upon behaviour. Thus, the first focus of New Labour's Social Exclusion Unit was not on the potentially disadvantaged generally but on particular groups, identified as 'at risk' of social exclusion by their behaviour. Rather than using the unconditional language of social justice, New Labour's policy statements on the labour market, family life and housing show a concern with promoting 'responsible' behaviour by individuals (Powell 1999).

'...as the Labour Party became New Labour, its notion of causation moved from the structural to focus on individual character as shaped by personal circumstance...' (Lund 1999, 448).

The ideal of an altruistic welfare state, facilitating social cohesion through collective discharge of responsibilities and the rights of welfare citizenship, was exemplified in the work of Titmuss (1974). Lund (1999) suggested the ideal is associated with old Labour social policy, developed in the forties and consolidated in the sixties. 'Universal altruism' was criticised by those Lund called 'New Labour gurus', because it failed to establish 'specific' obligations and a motivational force strong enough to sustain the welfare state. New Labour used the language of social problems in its discussion of social policy change. Lister (2001) argued that causal agents were thus individualised. The systemic issues of structural divisions that were the traditional concern of Labour governments were denied.

1.1.2. Motivation and Morality

There has been a revival of interest in agency. Deacon and Mann (1998) discuss the work of moral thinkers like Etzioni and Field who advised that motivation and the meaningfulness of choice should be taken into account in policy making. Their influence on New Labour's social policy has been reflected in attempts to restructure welfare to encourage responsible behaviour. The theoretical foundation for 'third way' approaches to social policy can be found in the work of Giddens in the U.K. (1998a, 2000) and in the concept of the reflexive citizen, to be discussed in chapter two.

Beliefs about human nature underpin welfare strategies. Taylor-Gooby (1999) highlighted the continuing influence of 'rational choice theory' in New Labour policies in the assumption that those who receive, provide and pay for welfare are motivated instrumentally. Murray (1994) argued that welfare programmes reward the immoral and anti-social behaviour of an 'underclass' of rational actors. Novak's (1998) critique also argued that the welfare state has been a source of moral corruption in the West, creating a 'spiritual crisis' that presented a greater threat than financial crises. Giddens's (1998b, 29) responded that there was no correlation between welfare expenditure and family breakdown across western societies. He nevertheless

asserted that welfare systems should encourage a spirit of entrepreneurialism, risk taking and resilience in the face of economic and social changes. In the third way, individual character is as much a topic of concern for social policy as social structure. The idea that rights can turn people into passive recipients was not solely the province of the New Right. Lister (2001) observed that New Labour embraced the concept of 'welfare dependency', using the example of Blair heralding '*the end of the something-for nothing welfare state*' (Daily Mail, February 10, 1999).

An understanding of human motivation became crucial to ensuring the effectiveness of social policy. Le Grand (1997) explored how faith in the altruistic, honourable 'knight-providers' and passive, disinterested 'pawn-recipients' of welfare has been replaced by a view of selfish and potentially dishonest 'knaves'. Therefore, actors must be constrained in their pursuit of self-interest by market discipline and a carefully managed structure of rewards and penalties. Policy changes included measures intended to ensure that the institutions and public servants responsible for policy implementation were motivated to realise government objectives. New Labour's performance management initiatives did not leave the motivation of councillors, bureaucrats and professionals to the discipline of market forces alone. Instead they reinforced the promise of greater financial rewards and status with the threat of loss of funding and power if outcomes were not achieved. The government's efforts to ally providers' interests with the pursuit of policy objectives include league tables, 'special measures' for poor performers, specific grants and 'earned autonomy' (Dept of Health 2000c, Hale 2001, Newman 2001). The government's concern with the motivation and behaviour of welfare recipients will be explored further later.

The similarities between New Labour's social policy and that of the 'progressive alliance' of Christian socialists, Fabians and new Liberals in the early twentieth century (before the party was committed to public ownership), were explained by Blair:

'The Third Way is not an attempt to split the difference between Right and Left. It is about traditional values in a changed world...uniting the two great strengths of left of centre thought- democratic socialism and liberalism-whose divorce this century did much to weaken progressive politics... Liberals asserted the primacy of individual liberty in the market economy: social democrats promoted social justice with the state as its main agent.' (Blair 1998, 1)

1.1.3. Modernisation and Social Justice

New Labour's approach was concerned with 'modernising' rather than rejecting social democracy (Blair 2001d). Labour struggled to reconcile economic and social priorities from the 1950s, according to Cowen (1998) and Lund (1999). The revisionary course led to Callaghan's confrontation in 1977 with 'hard and irreducible economic facts' and the separation of growth as a policy issue from any commitment to welfare expenditure (Driver and Martell 1998, Ellison

1997). The old objectives were re-defined rather than abandoned by New Labour, argued Powell (1999). The egalitarian aims of some of its policy changes (increased targeting of tax and benefit incentives) achieved 'redistribution by stealth'. The party's laudable commitment to end child poverty in Britain by 2019 was referred to in only one speech by Gordon Brown in the 2001 election campaign and was 'buried' on page 27 of its manifesto (Dean 2001b, 7). For New Labour, taxpayers are no longer the altruistic 'knights' in Titmuss's (1974) ideal of a welfare society. The government's reluctance to publicise the redistributing effects of some of its social policy initiatives, was attributed to a 'populism' that could ultimately undermine its achievements in addressing traditional Labour concerns:

'What we see here is a reading of public opinion as conservative and reactionary, which needs to be pandered to rather than challenged. This acts as a brake on the government's progressive policies..' Lister (2001, 429)

Blair nevertheless maintained that New Labour's policies employ modern means to achieve traditional ends.

'The values have not changed and will not change. They are based on the core belief in society, in community, in solidarity, the idea that we help each other as we help ourselves; and that this, not some laissez-faire individualism is the way to greater prosperity and a more fair and just society.' (Blair 2001a, 3)

The 'core value' that remains unchanged is that of social justice.

In his influential work on the 'third way', Giddens (1998a, 2000) maintained that there was a new recognition that the concept of 'equality' is relative and contextual. Still, it was a continuing concern with social justice that distinguished the policies of the 'left' from those of right of centre parties. Giddens argued that it was commonly accepted that there was no alternative to capitalism and differences are about '*...how far, and in what ways, capitalism should be regulated.*' (1998, 44), although no Labour Government ever proposed to do more than regulate capitalism. The history of the revisionist trend in Labour politics, the party's '*...courageous attempts to maintain its abiding welfare collectivist ethic*' and to reconcile economic and social objectives were described by Ellison (1997,45). He observed that it was when the Commission for Social Justice, appointed by John Smith, reported on the concept (social justice) as a hierarchy of ideas, that Labour began to distance itself from its traditional concerns with equality of outcomes, through redistribution across social classes. It began openly to pursue equality of opportunity and promoted the acceptance that not all inequalities are unjust. Blair's party in government has carried this forward.

'..New Labour has adjusted previous normative assumptions to endorse a conception of social justice as 'equity' rather than equality..' (Ellison 1998, 44)

Or as the prime minister was later to explain;

'The reason for the changes we are making is not for their own sake but because they are the means to a fairer society, where aspirations and opportunity are open to all, ... At the root of it all is a simple belief in fairness.' (Blair 2002b, 4)

The implication for social policy is help for those who help themselves. In this context even the mildly egalitarian effects of the minimum wage and income subsidies to working parents, can be explained by a New Labour concern with increasing labour market participation rather than old Labour's traditional concern with the relief of poverty. Thus the Blair government's policy on charging for community care services by local authorities, exempted income from employment but not disability benefits from means testing (Dept of Health, 2002a).

New Labour's move from universal to more targeted, selective benefits had a re-distributional effect, rather than raising standards generally for whole demographic groups irrespective of income. The significant impact of New Labour's efforts to eradicate child poverty has been assessed (Tonybee 2000, Tonybee and Walker 2001), if under-reported (Dean 2001b, 7). Lister (1998, 215) discussed what she called a paradigm shift in New Labour's thinking on the welfare state encapsulated by the expression *'from equality to social inclusion'*. The increasing use of means testing and 'targeting' income replacement benefits has obscured a *'fundamental shift further towards a residual safety net model'*. (Lister 2001, 434)

The universal –residual debate goes beyond the distribution of cash benefits. Within the public sector, there has also been a longstanding distinction between services provided for the population as a whole, irrespective of means, and the provision of a 'safety net' of services for those who cannot afford to make their own arrangements. In 1948 the National Health Service was founded on universal values, with services free at the point of use. The 1948 National Assistance Act repealed the Poor Law and separated responsibilities for the financial from the non-financial welfare of the poor, and the latter were allocated to local authorities. The personal social services relied on a 'residual', selective model and means testing for residential services from their beginning in the legislation. How this distinction between the highly regarded N.H.S and the stigmatised personal social services continued to impact upon contemporary social policy developments is explored in this case study. It is however worthy of note that when New Labour sought a popular mandate for its proposals for the reform of public services in a second term, the personal social services did not merit a direct mention (Labour Party Manifesto 2001, Blair 2001a+b).

Financial pressures and increasing responsibilities from the Conservative governments, during the 1992 to 97 period, led to tightening of eligibility criteria and extending charges in the personal social services (LGA/ ADSS 1998). The increasing significance of charges for community care services, in local authority finance was confirmed by the Audit Commission (2000) and identified as an obstacle to 'joined –up' action locally by health and social services

around individual need rather than bureaucratic boundaries. This was despite the exhortations of the Blair government to health and social services to work in partnership (Dept. of Health 1998a).

1.2 Globalisation and Social Inclusion

In New Labour's modernising agenda, economic and social policies are inextricable, because the world has changed. Jessop's (1994) model of the 'Schumpeterian workfare state' described two key transformations in advanced capitalist states, with the global trend to 'post-Fordist' strategic perspectives and discourses. A tendential shift from Keynesian demand side strategies to supply side 'workfare' initiatives and a 'hollowing out' of the nation state occurred. Jessop's thesis is that the Fordist state was an earlier phase in the development of international capitalism. New Labour accepted that national governments are constrained in the extent to which they can resist or ameliorate global trends and that the welfare state they recovered from the Tories had failed to keep up with economic and social change (D.S.S. 1998). Blair government's rejection of 'tax and spend' social policies in its first term and its concern with increasing the availability, quality and flexibility of the labour supply fit Jessop's model. For New Labour, the globalisation of world markets, the mobility of capital and the changing nature of work and family life meant that public ownership, Keynesian demand management and the universal provision of the welfare were no longer effective options (Jordan 1999). Instead it concentrated on supply side strategies and creating a stable, low inflation economy with investment in skills and flexibility in the workforce. Blair's government was constrained to focus in this way, not only by global, economic and social changes but also by the apparent conviction that redistributive policies were no longer acceptable to the electorate. The decision to increase national insurance contributions, was presented in the 2002 budget as a measure to increase investment in a collective 'good', the national health service. Access is based on universal principles and so is unlikely to disproportionately benefit the poor or 'working class' (Le Grand and Winter 1987).

The concept of inclusion, as an objective of social policy, originated in Europe (European Commission 1994, Wessels 1999). New Labour however shifted the focus in Britain from a balance between the economic and relational (social) aspects of exclusion to bringing the potentially excluded into the labour market (DSS 1998). As Lister (2001, 432) put it, '*paid work is fetishised as the citizenship responsibility..*' New Labour's strategies for assisting the young, the long-term unemployed, single parents, older and disabled people off benefits and into work reflect this concentration on supply side initiatives.

1.3 Participation, Responsibility and Social Cohesion

New Labour's aspirations for an inclusive society and the renewal of communities extended beyond the economic sphere. They were reflected in attempts to make institutions more

democratic, to involve citizens more in decision-making, to increase the accountability of local politicians and officials and to share civic responsibility alongside civil rights. For Blair (1996, 64) 'community' could no longer be another word for state or government:

'.. we should aim to decentralise power to people, to allow them to make important decisions that effect them... above all however we must create a society based on a notion of mutual rights and responsibilities..'

The goal of decentralising power was perceptible in the referenda that led to the establishment of the Scottish, Welsh and London assemblies and changes in local government accountability (DETR 1998). Restoring trust in government, leading to a more widespread willingness to participate remained an aspiration, given the low turnout at elections after 1997. Beetham (1996) argued that an extension of 'participation' could only be judged as democratic if it contributed to securing greater popular control over collective decision-making and greater equality in its exercise. Representative democracy requires that citizens are active in the exercise of their rights and have access to and control over the government. An alternative view is discussed by Ellison (1999), in an attempt to move on from the 'universalist – particularist divide' in contemporary welfare theory. Ellison explored the possibilities for increasing social inclusion through decentralised, deliberative conceptions of democracy and social justice, by enabling social groups to participate in framing and pursuing policy proposals relevant to their particular 'communities' of interest. In this case study the relevant interest group would be the 'disabled community' and the introduction of direct payments the policy proposal.

New Labour did not renounce the separation of policy and management, introduced by Thatcher's government. Instead the centralised performance management ethos became more pronounced and was at variance with communitarian philosophy that promotes local accountability. However in New Labour's efforts to account to and engage those it represented, the emphasis was on communities rather than on atomised consumers. As Stewart (1995, 290) observed, citizen's *wants* are not the same as citizen's *needs* and the 'collective' good is more than the sum total of individual interests '*..consumer responsiveness is no substitute for public accountability...*' New Labour tried to overcome other elements of the Tory legacy of accountability widely perceived as deficient and damaging: fragmentation, secrecy, the decline of democratic control and dogmatic commitment to market principles in the delivery of welfare (Rouse and Smith 1999). Blair's government also distinguished itself from Conservative administrations by its stress on collaboration, for example in its admission of 'outsiders' to government in the multiplicity of review groups that scrutinised policy. The stakeholder concept associated with Hutton (1995) found expression in Blair's (1996) 'Faith in the City' speech and New Labour's policy on social inclusion. However before Blair came into office Hutton (1997) prophesized:

'Unless an ascendant body of ideas can be assembled, underpinned by a political philosophy that incorporates a different world view and policy direction, Labour will find that in office it governs, in essence as a nicer group of Tories.' (17)

It was not apparent that New Labour's third way was underpinned by a political philosophy that incorporated a distinctive world view and policy direction. Instead, by trying to introduce, to the mixed economy in welfare, values, social stability and cohesion it appeared to confront the obsession with individual freedom and the pursuit of naked self-interest of the neo-liberalism associated with Thatcher. In so doing New Labour addressed traditional Conservative concerns. Alternatively, in recognising the role of 'reflexivity' or psychological factors, the need for social order and an ethic of trust for markets to work effectively, New Labour seemed to offer a more sophisticated version of Thatcherism.

New Labour maintained the link between welfare benefits and prices rather than average earnings. For social policy, this implied a concern to relieve absolute poverty, rather than to counter the divisive effects of 'relative deprivation'. The social dimension of poverty was revealed by Townsend's (1979) research a generation ago. The contemporary impact of the concept of relative deprivation on popular consciousness and discourse is demonstrated in the research reported by Dean (1999) that revealed people fear poverty more than they desire wealth. Doyal and Gough (1991) postulated a *universalisable* definition of human need. They argued that an evaluation of social policy required a distinction to be drawn between the principle that deprivation is relative and an acceptance that all needs beyond those of physical survival are subjective.

The roots of the stakeholder concept and New Labour's proposals for a reformed welfare system, within a moral framework of self-help and responsibility, were uncovered by Heron and Dwyer (1999). They identified their origins in 19th century neo-liberalism rather than earlier twentieth century versions of social democracy. New Labour's 'welfare to work' initiatives included 'workfare' aspects that made benefits conditional on co-operation (Ellison 1998, Driver and Martell 1998). Meanwhile the government relied on the voluntary co-operation of business in strategies for rebuilding communities and achieving inclusion. Therefore, according to one influential analysis, New Labour developed the concept of 'communitarianism' to make it more morally prescriptive than rights based, more individually than collectively focused and more concerned with the responsibilities of those at the bottom than at the top (Driver and Martell 1999). Or as Hutton (1996, 106) suggested :

'...there is a dangerous tendency for obligations, to search for work, to save for pensions and so on to be imposed upon the poor, while rights, -to enjoy low marginal rates of tax, to opt out into privileged private education are voluntarily exercised by the rich.'

Centre left policies should not be confused with ‘moderacy’ according to Giddens (1998). The third way’s concern with ‘life politics’ replaced classical social democracy’s focus on ‘emancipatory politics’ and required radical responses. The questions of life politics are about identity, quality of life, the private sphere and civil society. Giddens asserted that divisions between the old left and the ‘neo-liberal’ right, belonged to a bi-polar world that no longer exists. Blair’s (1998) claims that New Labour occupied the radical centre and transcended, rather than bridged, the traditional divisions with its *third way* approach were discussed by Driver and Martell (1998). They argued that New Labour did not reconcile the old tensions between individual autonomy and communal responsibility, but found a new way to manage them that was essentially ‘post-Thatcherist’. Class loyalties and redistributive aims were no longer relevant to a global capitalism. New Labour accommodated to the shift to the right in politics that Thatcher engineered but reacted against it through communitarianism, an inclusive ‘one nation’ outlook. Driver and Martell concluded that this was not just a matter of technical adaptation but of ideology.

The third way is defined by what it is not, according to an alternative analysis offered by Powell (2000). The term does not have a coherent and consistent meaning, has internal contradictions and is not applied uniformly in all sectors. The ‘third way’ was not based on a clear ideology or ‘big idea’. It was pragmatic, concerned with, as the New Labour government claimed elsewhere, ‘*what works*’ (Dept of Health 1998a, 1.7). Powell argued that New Labour felt limited in the options available not only by global trends and the belief that the electorate is unwilling to pay higher taxes. It was also constrained by the legacy of the Conservative government’s radical programme:

‘... Labour inherited a political landscape not of its making. Its pragmatic response was to accept or modify the reforms that appeared to work and reject those that did not.’
(Powell 1999, 298)

A central part of the Blair government’s inheritance was the ‘unfinished business’ of welfare reform in Clarke and colleagues’ (2000) account. That is a complex set of tensions, ambiguities and contradictions to which New Labour responded. The development of this discussion will focus more on the case study policy initiative in subsequent chapters and will consider whether the ‘unfinished business’ idea is discernible in New Labour’s approach to the last Conservative government’s legacy of reform, with respect to direct payments for community care.

1.4 The ‘Who, Why and How’ of social policy

This introduction to New Labour’s approach concludes with a review of the various critiques of the recent development of British social policy using the framework of the key questions proposed by Driver and Martell (1998). Attention is drawn to their relevance to New Labour’s

policy on direct payments. This discussion will lead to the consideration in chapter two of this particular initiative as a '*third way*' social policy reform.

1.4.1 Who pays for and who benefits from the welfare state?

A post war 'consensus' on the welfare state amongst policy makers, survived until the Thatcher government demonstrated that radical change was not the sole province of the Left. The New Right critique of the financing of public services and social security concerned itself particularly with the way that 'high' taxes curbed the freedom of the better off and undermined charitable endeavors. Meanwhile 'welfare' expenditure removed the incentives for the worse off to work, save and provide for themselves and nurtured a 'dependency culture', together with an irresponsible attitude to family life (De Jasay 1992, Green 1999, Laing 1991, Murray 1996). The state, which had been conceptualised as the embodiment of the collective interest, was redefined as at best a constraint on individuals, a domineering and over-protective parent substitute. From the 1970s concerns about the 'nanny-state' gained ascendance in the British mass media and to some extent in popular consciousness, in a way that the critique of the welfare state from the intellectual left did not. Pearson (2000) identified the influence of what she called 'scroungerphobia' on decisions made in the introduction of direct payments for community care services in the late 1990s. Her research highlighted how procedures introduced by one council to prevent abuse of the 'system' by disabled people undermined the empowering qualities of this policy initiative.

The universalist ideal of the welfare state, and many of its institutions and benefits, were perceived by earlier social policy academics and politicians as promoting social cohesion and a sense of community (Titmuss 1974, Marshall 1996). Nevertheless condemnation of the effects of the collectivist model of welfare on motivation and behaviour was made during the 'consensus' period (Hayek 1960). The regressive impact of fiscal and occupational welfare on the distribution of disposable income within post war society was observed even earlier (Titmuss 1958). In the 1980s research by Le Grand (1982), fuelled criticism from the Left that most of the redistribution engineered by British social policy happened across individual life cycles and within rather than between social classes.

Criticism of the version of social justice institutionalised in the narrow contribution based entitlements of social insurance systems came from a feminist standpoint (discussed by Jordan 1999, Pierson 1998). Based on the Beveridgean 'male- breadwinner' model, the welfare state not only failed to keep pace with changes in family life, it maintained the stigma historically associated with a residual, selective system for those who had not 'earned' their 'rights' through the traditional labour market.

'... on the one side stands the universalist plea for greater social justice and equality, a 'fairer' allocation of goods to mitigate the inegalitarian effects of the market and to generate social cohesion; on the other demands for the recognition of diversity and 'difference' sustain the view that universalism can, paradoxically be socially exclusive..' (Ellison 1999, p.59)

New Labour targeted benefits more selectively, cut income tax allowances that benefited the middle classes, and supplemented the earnings of non class based demographic groups vulnerable to social exclusion, including single parents and disabled people. It claimed its social policies encouraged responsible behaviour. However Heron and Dwyer (1999) highlighted similarities between the conditions attached to the rights of citizenship through the 'new contract between citizen and state' fundamental to New Labour's social policy (D.S.S. 1998) and the principle of 'less eligibility' that underpinned the 19th century Poor Law. Consistent with this analysis was Dwyer's (1998) observation of a process whereby welfare provisions once regarded as rights were evolving into market commodities.

The following chapter discusses how Major government empowered councils to give direct payments to some disabled people to arrange their own care through individual market transactions. New Labour attempted to extend the availability of direct payments for community care to a much wider constituency of service users than were eligible in the Conservative version of the initiative. However direct payments were not rights based, and under New Labour continued to be made according to the eligibility criteria of particular councils, subject to the assessment of individual applicants by professionals. One implication was that some social groups continued to experience greater barriers to access than others², underlining the 'who benefits?' question. The lifestyle, standard of living and quality of life for some British citizens was thus dependent upon where they lived, with consequent limitations on choice, control and geographical mobility. The part played by local policy and decision-makers, in determining eligibility for and the allocation of resources to those in need of assistance in their particular communities, mimicked the role of the pre- 1948 Poor Law Guardians.

The ascription of need by welfare state agencies and professional experts was said to actively disempower disabled people, in contemporary British literature on disability (Oliver and Barnes 1998). This 'orthodoxy' was challenged by Handley (2000) who suggested that the rights based approach to promoting the interests and inclusion of disabled people had two major weaknesses. The concepts of 'rights' and 'self-defined' needs have been under- theorised and the conflict between the competing claims generated by the pursuit of rights based on self defined, rather than ascribed, need were given insufficient consideration. There was a debate within the disability rights literature about whether direct payments, within the British social policy

² For example Witcher and colleagues's 2000 research found no-one from an ethnic minority in receipt of a direct payment in Scotland.

context, progressed or compromised the cause of disabled people, in their struggle against oppression and exclusion. Alternative interpretations of 'need', 'rights' and the empowering and disempowering qualities of the relationship between users and providers of welfare services, are therefore relevant to the case study initiative.

1.4.2 Why do we have welfare provision?

New Labour's social policy attempted to combine, rather than reconcile, economic and social objectives. It focused not on collective interests but on the individual as a member of a community and on promoting social cohesion by making rights conditional upon the fulfillment of responsibilities, in the sense of Aristotilean 'civic duties', as well financial obligations (Jordan 1999).

'..no society can ever prosper economically or socially , unless we use the talents and energies of all the people rather than just the few, unless we live up to the ambition to create a society where the community works for the good of every individual and everyone works for the good of the community.' (Blair 1996, vi)

Contradictory notions of citizenship are identified by Powell (1999) in New Labour's ideas on social inclusion and its symbolic revision of 'clause 4'. Jordan (1999) suggested there is confusion in policy discussions between the interactional code of reciprocity and the market place rules of fair exchange. He warned that to attempt to extrapolate from intimate associations (family, friends and neighbours) to large scale impersonal ones requires coercion because the moral sanctions needed for voluntary reciprocity are not available.

New Labour's declared aspirations were not egalitarian. It planned to reduce the inequalities of opportunity and access because they wasted resources and talent. It intended to create one nation of stakeholders because of the costs of social exclusion and the threat it presented to social order. For even the most vulnerable and economically inactive, it aimed to promote independence from welfare service provision.

'..the guiding principle of adult social services should be that they provide the support needed by someone to make the most of their own capacity and potential..' (Dept. of Health 1998a , 2.5).

Direct payments were amongst the measures promoted for the achievement of policy objectives:

'..direct payments are giving service users new freedom and independence in running their own lives and we want more people to benefit from them..' (Dept. of Health 1998a, 2.15)

In New Labour's 'modernising' programme for public services, tensions between objectives were masked by the deployment of a managerial discourse. Newman (2000) asserted that this

managerial discourse also neutralised and displaced the conflict between the requirements of different stakeholders including government, citizens, users and ‘communities’.

1.4.3 How are welfare services to be delivered?

The portrayal of the self-serving, expenditure maximising state official, in Niskanen’s (1973) and Tulloch’s (1976), critiques of public services echoed earlier neo-liberal critiques of the welfare state (van Hayek 1960) and was supported by other analyses from the Institute of Economic Affairs (De Jasay 1992). This right wing view of inefficiency and ineffectiveness was credited with inspiring the introduction of quasi- market structures and competitive discipline into the institutions of public services from the late 1980s (Le Grand and Bartlett 1993).

The ‘public choice model’ of bureaucracy was challenged by Dunleavy (1986). He offered a radical alternative to the ‘budget-maximising’ theory that predicted an inherent tendency in public services to over provision, beyond the point at which benefits match the costs incurred. Instead, Dunleavy explained the apparent ease with which ‘privatisation’ was achieved during Thatcher’s administration. His ‘bureau-shaping’ model of the motivation of self interested, senior officials predicted that they would pursue privatisation beyond the point of efficiency, facilitated by an under estimate of the social costs (negative externalities) of reducing the size of the public sector. The costs of excessive (in economic terms) privatisation are borne not by senior bureaucrats but by rank and file state workers and service users/ citizens. The findings of later research into the heavily privatised social care market offered empirical support for Dunleavy’s thesis (Ford, Quilgars and Rugg 1998, Henwood 2001). Nevertheless, from an alternative standpoint, recipients of welfare had often complained about the inflexibility and unresponsiveness of public services and the oppressive and disabling attitudes and practices of those delivering them (Barnes 1997, Morris 1993, Oliver 1991). Hence Giddens (1998) could argue that some welfare institutions are ‘*..bureaucratic, alienating and inefficient.*’ (113)

There was therefore a broad base of support for the principle of reducing the power of professionals and the alleged dominance of provider interests in the welfare system. However the organisational changes that took place under the Conservative governments shifted power from professional providers and bureaucratic administrators to new public managers and budget holders rather than to those who use welfare services. New Labour’s contribution has been a ‘pragmatic’ approach to who delivers;

*‘..The last government’s devotion to privatisation of care provision put dogma before users’ interests and threatened a fragmentation of vital services. But it is also true that the near-monopoly local authority provision that used to be a feature of social care led to a ‘one size fits all’ approach where users were expected to accommodate themselves to the services that existed. Our **third way** for social care moves the focus away from who provides the care, and places it firmly on the quality of services experienced by, and outcomes achieved for, individuals and their carers and families.’ (Dept. of Health 1998, 1.7)*

Blair's (1998) account of the *third way* was criticised as caricaturing the Left and Right and in so doing omitting some striking features of each (Clarke and colleagues 2000). The association of the 'Old Left' and collective approaches with 'statist' provision ignored the 'New Left' critique of the oppressive and discriminatory nature of the institutions of the welfare state and the influence of the new social movements on that critique (Andrews 1999). The challenge of the disabled people's movement, to the legitimacy of professional knowledge and power in the design and delivery of social care services, could be explained from this perspective. One manifestation of this was the demands made by disabled people for control over the resources they require to achieve and exercise their rights and responsibilities as citizens, through direct payments.

A post war mixed economy in public service delivery continued through changes in the party in power, including the administrations of Thatcher and Major. Earlier Labour governments sought to use state ownership and collectivist provision to ameliorate the inegalitarian effects of capitalism, while protecting individuals when needed through their own life cycles. The traditions of 'municipal socialism' were resilient during the long Conservative rule, with Labour controlled councils preserving their role as major providers of jobs and services in social care. The implementation of government policy on direct payments before the New Labour's White Paper on social services (Dept. of Health 1998a) occurred largely outside of traditional Labour strongholds. New Labour demanded that even personal social services be subjected to the competitive pressures of 'best value' testing (D.E.T.R. 1998). It attempted to bolster the role of the user as consumer in community care further than even its pro-market predecessors, by promoting the extension of individual purchasing power through direct payments, (Dept. of Health 1998a, Dept. of Health 2000a, Dept of Health 2001). Langan (2000) argued that New Labour tried to establish that its own 'third way' version of the mixed economy was something new and above all something 'modern'.

In the field of personal social services, it was important for the government to establish that existing arrangements had proved a failure to prepare the way for its 'reform' programme. New Labour's White Paper (Dept. of Health 1998a) made repeated references to poor services, widespread inefficiency and low standards:

'There is an implicit assumption that local agencies are viewed as guilty of incompetence before being proved innocent' (Hunter 2001, 55)

The implied criticism of existing resource allocation systems in the first guidance on direct payments issued by New Labour (Dept. of Health 2000a) presented the individual service user as more able and motivated to manage the resources s/he needs efficiently than social services decision-makers (3, para 2). Blair's account of the resistance of public service workers to his programme of welfare reform will be discussed in chapter three.

New Labour recognised that leaving the delivery of welfare to the market created the potential for fragmentation, duplication, resource waste and lack of accountability. It claimed to promote partnerships and 'joined up thinking' by all those with responsibilities for service delivery. This meant adopting a strategic approach to meeting objectives set by both central government and local communities and the use of competition as just one of the tools for achieving 'best value' (D.E.T.R. 1998). Blair's government may however have been remedying design flaws to advance the reform of the state beyond the New Right's efforts. Clarke and colleagues (2000) asserted that New Labour was simply addressing some of the fragmenting effects of the organisational changes in public services that occurred with Conservative governments, through conceptions of 'joined up government' and 'partnerships'. Clarke and Glendinning (2002) argued that partnership is a word of '*obvious virtue*' and Blair's government was not the first to promote it as a means to achieving policy ends. Nevertheless New Labour's efforts to encourage and ultimately impose partnerships went further than previous attempts.

Despite the similarities between the Conservatives' 'new public management' and New Labour's 'modern management', Newman (2000, 60) argued that the latter attempted to transcend the fragmentation and limitations of consumerist and client-based models by promoting user-participation. In recommending how direct payments were to be developed and delivered by individual councils, the government promoted partnerships with local voluntary groups and the involvement of service users, whilst simultaneously advising that direct payments should be assimilated into wider corporate and inter -agency strategies.

CHAPTER TWO

Direct Payments :A Third Way Approach to Community Care?

'Developing the potential of our people is our goal; and everything else is a means to it. So there is no predisposition towards public or private in the pursuit of our aims or of Government or state for its own sake.' (Blair 2001a, 1)

2.0 Introduction

Chapter one outlined the academic debate on New Labour's social policy. The contribution of Blair's governments to policy making and implementation, in offering an alternative to an ideological domination by either the public sector or the market was discussed. This chapter begins to explore the implications of New Labour's approach to policy effectiveness through a particular case study example. The historical and political context for the extension of direct payments by Blair's government is outlined, along with the characteristics that make this typical of a 'third way' initiative.

2.1 Community Care and Direct Payments

Direct Payments are cash sums given to individuals by local authority social services departments, in lieu of community care services, based on an assessment of the person's care needs. The literature usually traces their origins to the struggles of disabled people against oppressive institutions and environments. Morris (1997), Campbell and Oliver (1996) described how disabled people demanded control over the resources they require to enjoy the opportunities and experiences most people expect, to enable them to achieve self-determination and independence. During the 1980s the work of Brandon and Towe (1989) in Britain and Salisbury and colleagues (1987) in Canada gained prominence, arguing the case for 'service brokerage' as an empowering alternative to service systems, dominated by professional interests and discourses.

In the nineties the Conservative government initiated its 'community care' policy, implemented within a mixed economy (Griffiths 1988). Market discipline was introduced into the service infrastructure with the objective of widening consumer choice and achieving 'value for money' (D.H.S.S. 1989, 5). Councils were not compelled to tender competitively for social care provision, but were obliged to spend eighty five per cent of a new central government grant for community care services in the independent sector. The intention was to reduce the role local authorities had played as the major providers of social care services, since the repeal of the Poor Law in the 1948 National Assistance Act. Late in the Major administration, 'direct payments' to users of community care services were introduced by legislation, following two failed Private Member's Bills (Dept of Health 1996) and the campaigning efforts of disabled people. As campaigner and academic Oliver (1998, 87) put it:

'The 1996 Act is by no means perfect... but it does represent a major step forward in disabled people's ongoing struggle for inclusion into the mainstream of British society.'

Others have questioned whether the Conservative government's promotion of direct payments was another 'consumerist strategy', based on a narrow interpretation and a half-hearted application of the principles of independent living (Barnes and Prior 1995, Barnes and colleagues 1999, Priestley 1999). Councils were given the leeway to draw on an individual, rather than a social, model in implementation. It was argued that direct payments might disempower disabled people by dividing the interests of service users from others, including those who provided the assistance they need (Ungerson 1997). Nevertheless, research highlighted the benefits for the relatively small numbers of users who received direct payments, despite the problems they sometimes experienced due to inappropriate support and monitoring systems and inadequate resources (Glendinning and colleagues 2000a, +b, Kestenbaum 1999, Maglajic, Brandon and Given 2000). As one person explained: *'The quality and flexibility I now have is. ... worth every second of any stress'* (from Evans and Carmichael 2002, 4). Pearson (2000) contrasted the approaches of a Conservative and a Labour council to using their powers under the 1996 Act. Alternative discourses (market or social justice) dominated and influenced the development of direct payments. The impact of each discourse was to restrict the potential benefits to social care users from direct payments

The New Labour government expressed its determination to ensure that direct payments were extended, and recommended the involvement of disabled people in the development and management of local schemes (Dept. of Health 1998a, 2000a). The case study of direct payments thus offered an opportunity to explore the implementation of a 'third way' policy initiative. The objectives of the initiative were to promote independence and inclusion through the engagement and empowerment of service users as active citizens, rather than atomised consumers, and appeared to draw on a social model of disability (Morris 1993, Oliver 1998).

2.1.1. Background to direct payments and community care policy

Councils were given the power to give cash to users of social care services, by the Community Care (Direct Payments) Act of 1996. However some authorities were already giving people money to buy their own care services, through grants to independent organisations. These 'third parties' then passed care funds on to individuals. The history of individuals being given public money in recognition of their care needs is longer and reflects the campaigning efforts of disabled people. It features the introduction of the Attendance Allowance (later developed with the Disability Living Allowance) as a non- means tested, non- contributory benefit for disabled people from 1971. The Independent Living Fund was a Trust established by central government in 1988, to make means tested direct payments to individuals to buy their own services. However the 1996 Act left the decision to make direct payments for community care to each local authority.

The principle of disabled people managing their own care arrangements and budgets was strongly advocated by the disabled peoples' rights movement as: *'...the most empowering commissioning system yet devised..'* (Holman 1998, 20) The research suggested that direct payments gave choice and control to the user as purchaser of services (Holman 1998, Zarb and Nadash 1994). In the 1996 Act, policy followed practice in the relationships between some disabled people and some local councils.

Williams (2001, 470) asserted that ;

'In so far as this move to direct payments has also been... the consequence of demands from the disability movement, then it indicates ... a challenge to the assumed, all-encompassing dependency of the "cared for" in care relations and practices.'

Direct payments as a purchasing method, could also lay claim to the support of New Right commentators. For example economists of the Institute of Economic Affairs suggested that the introduction of market relationships into the traditional structure of welfare provision by the 1990 NHS and Community Care Act would not meet the demands of the public choice model of empowerment (Laing 1991). Spending and decision-making power remained with council bureaucrats rather than with the end user of services in the social care 'market'. The principle of reducing the role of public servants in public spending decisions had ideological and theoretical support from the 'neo-liberal' strand of thinking about the welfare state (Giddens 1998, 12). It was promoted by the disability rights movement associated with the 'New Left', from the standpoint of a non-class based group who also experienced the universal and collective provision of state welfare as oppressive (Oliver and Barnes 1998, Shakespeare 1993).

'To support a system in which the individual who needs the help has the power to determine how that help is delivered is not to support a right wing individualist agenda. Rather it is about promoting collective responsibility for protecting individual rights. Direct payments are one way of doing this.' Morris (1997, 59)

Economic theorists evaluating the 'market reforms' in the public sector recognised that the 'invisible hand' of market forces had not been fully uncuffed³ (Bartlett and colleagues 1998, Le Grand and Bartlett 1994). The policy changes meant the substitution of administrative with contractual arrangements, and introduced the principle of competition and budget control on the supply side of 'quasi markets'. However because purchasing budgets and decisions were not passed on to service users, the demand side of the market did not feature numerous competing purchasers able to pursue their own interests and the efficient use of resources. Instead these markets lacked 'conditions for success', that is the characteristics identified as necessary for the efficient allocation of resources and cost effective service delivery.

There was a broad base of support for individualised purchasing but most councils did not immediately use the new powers granted by the 1996 Act (Dept of Health 1998a, 2.14).

Research, comparing both user satisfaction and the costs of providing services or making direct payments through third party schemes, had demonstrated the potential gains to be made on both outcome measures (Zarb and Nadash 1994). Nevertheless the Major government gave councils discretionary powers rather than duties and thus did not seem concerned to oblige non-responsive social services departments to create a market in community care, with real paying customers. This was despite his avowed concern with accountability to individual citizens. Major's apparent interest in promoting a 'customer service' culture in the public sector, however, was distinct from his predecessor's focus. The original 'community care' policy, seemed more concerned with the shift of power between interest groups by the attempted introduction of private sector values and practices into public services, through the 'New Public Management' (Dunleavy and Hood 1994, Langan 2000).

So to go back a step further, the new public management and contract culture, introduced by Thatcher's community care programme (D.H.S.S. 1989), had stopped short of following the logic of the market to the point of giving individual citizen/ customers budgets to manage. Individualised purchasing power was not allowed to subject social care services to the discipline of a market where users could have, in principle, chosen where and what to buy. In education, however, the principle of parental choice linking funding with pupil numbers had effectively created a 'voucher' system to buy school places. Cutler and Waine (1997), contrasting the characteristics of markets in health and education, suggested the reasons for the reluctance to introduce individualised purchasing to the NHS were political rather than economic. The reluctance of politicians to subject health services to the market pressures of consumer preference, continued in the initial exclusion of health care from direct payments.

There were some aspects of the Conservative governments' community care policy that withdrew purchasing power from individuals. The NHS and Community Care Act removed the right of income support claimants to buy residential care directly in the independent sector from 1993. Instead funds were transferred to social services departments who became almost 'monopsonistic' purchasers in local community care markets. User access was made conditional upon professional assessment and on the discretion and budgets of individual councils. Access to the Independent Living Fund direct payments became similarly restricted. Although consumer 'choice' was intended to empower service users (D.H.S.S. 1989 1.8), these two developments represented a redress in the power balance from users back to local politicians and professionals. The transfer of the control of these funds to the administration of local authorities recreated the parochial, residence based arrangements of the pre-1948 Poor Law, which were to be reinforced by the Blair government.⁴

³ To develop Adam Smith's (1961) metaphor.

⁴ The Health and Social Care Act 2001 transferred the 'preserved rights' benefits enjoyed by pre- 1993 residential care users to local authorities.

Councils' powers to make direct payments for community care did not become effective until April 1997, just before New Labour's 'landslide' into government. Direct payments continued to spread slowly during the next two years, when implementation was based on the policy and practice guidance left by the Conservatives. In December 1998 Blair's government presented its proposals for *'Modernising Social Services'* (Dept. of Health 1998a). The government expressed support for direct payments and its intention to extend their availability to the majority of community care users. New Labour's community care policy therefore appeared to extend the logic of the market reforms and the consumerist philosophy further than either the Thatcher or Major governments attempted to. It created the potential for large numbers of individual citizen/ purchasers to exercise consumer choice, rather than leaving the demand side of the market to professional and political decision-makers in local authorities.

2.2 New Labour's Policy Programme

Direct payments have characteristics typical of New Labour's social policy and its proposals for *'Modernising Social Services'* (Dept. of Health 1998a 1.4). The recurrent themes in the speeches, statements, consultation documents issued by the 1997 Labour government heralded a framework of policy reforms. The concept of 'joined up thinking' emphasised the need for a coherent, consistent and collaborative approach to implementation. The White Paper proposed a *'third way'* between the last government's ideological commitment to privatisation (said to have put dogma before user interests and to have threatened the fragmentation of care services) and the historical *'near monopoly'* of local authority provision (note the market terminology). The latter led to a *'one size fits all'* approach (Dept of Health 1998a 1.7).

The promise to allow no dogma or vested interest to stand in the way of the government's plans for change was applied to the whole public sector in New Labour's second term. In one of several major speeches on public services in which social services did not merit a direct reference, the prime-minister asserted:

'It is not just investment that has held back reform. We have also been held back by ideological clashes, going back decades, which have distracted from the real challenge of improving our public services.' (Blair 2001b, 3)

The characterisation of 'New Right' and 'Old Left' approaches to social services is relevant to the differences revealed by Pearson (2000) between the discourses prevailing in the approaches to direct payments of a Conservative and a traditional Labour authority. However the polarised imagery promoted by 'third way' thinkers has been criticised as caricaturing and over simplifying the variety of political and theoretical influences on critiques of the welfare state (Andrews 1999, Clarke and colleagues 2000) including the contribution of the 'New Left' social movements.

The third way appeared to offer a change of emphasis rather than of overall direction (Dept. of Health 1998a 1.7). Taylor-Gooby (1999) discussed how the objectives of the Conservative's community care policy had New Labour's support. However, the obstacles identified by the Audit Commission (1992, 1997a, b+c), to inter agency working, user involvement, efficiency and effectiveness, were to be overcome through a more pragmatic response. For councils this meant acceleration in the drive towards a competitive market in community care. Under Major, social services (unlike other council provision) had not been subject to compulsory competitive tendering, a system that obliged councils to buy goods and services from the lowest bidder in the marketplace. However they were not to be exempt from the New Labour alternative 'best value' testing (D.E.T.R. 1998,7.5). The 'best value' project demanded that councils look beyond price, to the quality and cost effectiveness of services and to consult the public.

The government announced its determination to see the use of direct payments extended. The Health and Social Care Act 2001 introduced the promised obligation from April 2003, yet councils were left with the discretion to judge which individuals would be eligible for these cash payments and how much would be paid.

2.2.1. Independence, Inclusion and the Rights and Responsibilities of Citizenship

Direct payments provide an appropriate case study to explore the policy action process because they exemplify New Labour's proposals for 'modernisation' and '*..welfare reform and social inclusion by promoting independence..*' (Dept of Health 1998a, 2). Blair's government claimed that the Conservative government fostered: '*...a culture of dependency rather than one of enablement..*' (Dept. of Health 1998a 2.9).

Therefore:

'...one way to give people greater control over their lives is to give them money and let them make their own decisions about how their care is delivered.'(Dept. of Health 1998a 2.13)

Direct payments also

'...promote independence, and they aid social inclusion by offering opportunities for rehabilitation, for education, leisure and employment for people in need of community care.' (Dept. of Health 2000 3, para 1)

The extension of direct payments was also explained in terms of the objective of economic efficiency based on the rational decision-making of individual purchasers/ users,

'Day to day control of the money and care passes to the person who has the strongest incentive to ensure that it is spent properly on the necessary services and who is best placed to judge how to match available resources to needs..' (Dept. of Health 2000a, 3, para 2.)

The reasoning behind this statement is consistent with market theory (Le Grand and Bartlett 1993). The individual is enabled to optimise her individual welfare by the freedom to use

available money in a way that ensures that the marginal benefit derived is equal to the marginal cost. The 'marginal utility function' means that the individual balances cost against quality according to personal preferences. Through large numbers of unconnected individuals competing to get the best deals they can for themselves from available funds, social welfare is maximised by the optimum use of resources overall.

The example of direct payments illustrates the role advanced for the market within the government's policy programme, as a means rather than an end in itself. It appears to be one of the measures through which New Labour intended to make the market work for the people and not vice versa. Giving users choice, in how they use their direct payments, could assist councils in satisfying the overarching policy imperative that all commitments of public funds were tested for 'best value' (D.E.T.R.1998 p.3, para.19). This recognition of the value of users' knowledge and experience, of course, represents a challenge to the power base of professional expertise. It is one that was being made by the disabled people's movement before the 'consumerism' of the 1990s (Campbell and Oliver 1996) when 'empowerment' was redefined by the Conservative government (Dept of Health 1991,7).

The symbiotic relationship between social rights and responsibilities was central to the modernisation programme and particular initiatives:

'...At the heart of the modern welfare state will be a new contract between the citizen and the government....To help all individuals and families to realise their full potential and live a dignified life, by promoting economic independence through work, relieving poverty where it can not be prevented and by building a strong and cohesive society where rights are matched by responsibilities' (D.S.S. 1998, 80)

Hence direct payments :

'... give users greater control and independence, but this increased freedom is inevitably accompanied by increased responsibilities...' (Dept. of Health 2000a, 7)

In keeping with the wider welfare reform agenda, one objective of direct payments as a service strategy was to enable community care users and carers to enter employment (Dept. of Health 2000a) and earned income was therefore exempt from charges (Dept. of Health 2002a).

In the spirit of 'social inclusion' that characterised New Labour policy initiatives, the revised guidance extended eligibility to previously excluded groups of users. From February 2000, people over sixty-five could not be refused a direct payment on the grounds of age. The stringent 'able and willing' test, that allowed councils to exclude all but the most articulate, informed and assertive users from eligibility for direct payments, was removed. Instead potential users were to be assessed as 'able and willing *with assistance*'. A role for trusts was introduced for those who could not manage the detailed aspects of their care packages and budgets, but wanted to have control of their lives. Councils were instructed not to prejudice the

appropriateness of direct payments to whole user groups, but to assess each applicant's case on its merits.

'Choice' for New Labour, however, was not just about efficient use of resources (D.E.T.R. 1998). Similarly best value was not just about competition facilitated by individual 'exit' strategies, where individuals can take their custom elsewhere (Servian 1996). The Blair government's view of the responsible stakeholding citizen also involved empowerment through the decentralisation of decision making: '*... we should aim to decentralise power to people, to allow them to make important decisions that effect them.*' (Blair 1996, 64) Meanwhile, researchers identified the empowering qualities of direct payments for disabled people (Evans 1998, Holman 1999). Blair continued to express his government's commitment to New Labour's ideals of empowerment as he launched his campaign for re-election:

'We are not crypto-Thatcherites. We are not old-style socialists... We believe in empowering all our people.' (Blair 2001a, 5)

An intellectual underpinning for the 'third way' approach to welfare and in particular to the model of the 'active citizen' was provided by Giddens's (1989, 1998 and 2000) analysis. *Risk society theory* offered an idealist rather than a material account of social change. Giddens argued that cultural mobilisation, the development of a post-traditional social order and a 'social reflexivity' has made people increasingly aware of themselves as social actors. They are more confident about their own capacity to make choices and handle risks and have less confidence in the traditional welfare state and its institutions.

A note of caution has been introduced about using 'risk society' theory as the basis for third way approaches to policy effectiveness. Drawing on Le Grand's (1997) analysis of the increasing dominance of rational actor theories of behaviour in political science, policy analysis and the understanding of motivation, Taylor-Gooby (2001) observed that differences in the impact of social change and its associated risks on different groups were largely unaddressed by Giddens. This was in contrast with social policy's traditional concern with inequalities and the conflicts of interest between social groups. He attempted to subject the risk society thesis to empirical scrutiny through examining the experiences and attitudes of different social groups to risk. He found that the experience of risk was not uniform across society, that the effect of disadvantage was cumulative and that social changes were increasing inequality. Hence, while middle class respondents perceived increased choice as positive, working class respondents associated it with greater insecurity. Taylor-Gooby (2001, 210) therefore concluded:

'It would be unfortunate if ... the Third Way became an ideology serving the interests of the more privileged classes by denying the continuing importance of class divisions in vulnerability.'

Or as Brandon and Brandon (2002, 17) observed, in the particular context of social care;

'In this great tide towards user involvement in service provision there are immense dangers. One major problem lies in the drift towards the "dictatorship of the articulate"....'

A psycho-social approach to welfare research that considers the interplay of internal and external, subjective and objective factors and their relevance to 'reflexivity' and agency was advocated by Hoggett (2001). He contended that Giddens's account of the active welfare subject was not robust enough to confront the real experiences of powerlessness and psychic injury that can result from injustice and oppression. The attack on the 'dependency culture' in Blair's social policies under the cloak of social inclusion: *'..reveals a hatred of the very idea of dependency and a refusal.. to accept that some people need continuing support to cope with their lives.'* (Hoggett 2001, 44). Hoggett identified weaknesses in Deacon and Mann's (1999) definition of agency as actions, decisions and behaviours that represent some measure of meaningful choice. Their definition excluded non-reflexive action and so did not address situations in which people act impulsively, against their better judgement. Hoggett also distinguished first and second order agency amongst welfare actors. In the first, the agency available to actors is limited to 'working the system' whereby individuals get the most from what is available, possibly at the expense of others. The second is where actors challenge and succeed in changing the system. Hoggett concluded that welfare policy that aims to enable people to take responsibility and to make rational choices will not succeed unless it can confront both the effects of negative emotional capabilities and the reality of experience. Greener (2002) married the model of agency offered by Hoggett with Bourdieu's social theory (in particular the concepts of 'habitus' and 'capital') to challenge the assumptions made about agency in New Labour's social policy. The framework offered by Greener is relevant to the community care context and Bourdieu's metaphor of agency as a game can be used to explore the interactions between welfare bureaucracies and service users. Public servants implementing community care policy hold economic capital (public budgets), cultural capital (expert knowledge) and symbolic capital (professional status). The habitus⁵ of the user may elicit a more responsive service where her social status is recognised (symbolic capital). Users must play the system to get the best care possible through acquiring knowledge of what and how services are potentially available.

The concepts of first and second order agency, together with differential access amongst social groups to the means to manage the risks they confront and the confidence to take greater responsibility for their own 'welfare', are relevant to expectations and experiences of direct payments. When the rules applied to direct payments are not generally known and transparent there is a danger that those with the correct 'habitus' and 'capital' may gain favour at the expense of others. This would be an example of the 'first order agency' identified by Hoggett

⁵ A set of dispositions that incline agents to act and react in certain ways.

(2001). The struggle of the disabled peoples' movement to achieve legislative changes obliging councils to offer direct payments to all community care users (Dept. of Health 2002) is an example of second order agency. However the government's expectation that this policy prescription will lead to the widespread use of direct payments assumes a '*reflexive, actor as subject*' model of agency (Hoggett 2001, 47). This model may not be appropriate to many community care users.

2.2.2. Direct payments and 'joined up thinking'

The phrase 'joined up thinking' is associated with New Labour's programme. Direct payments are intended to support the wider objectives of the coherent, consistent strategies expected of the responsible authorities (Dept. of Health 2000a). Blair's government attempted to address the fragmenting effects of the Conservative welfare reforms, without fundamentally changing the organisational arrangements, through promoting partnerships rather than competition and the participation of the user/ citizen. In Newman's (2001) analysis 'partnership' was integral to New Labour's discourse through which it attempted to transcend the vertical, departmental structures of government.

'... the government is fostering a new spirit of partnership working. The government will play its part in helping this partnership approach by removing legal and other obstacles to joint working and by adopting the same principle of partnership and joint working in policy making as we expect from those who are delivering the services at the local level..' (Dept of Health 1998a 6.3)

Despite these proud boasts about the government's good intentions for policy effectiveness, the extension of direct payments illustrates some of the difficulties experienced locally in developing and implementing coherent joint strategies. These difficulties arose from an apparent slowness in 'joined up thinking' centrally. The relationship between direct payments and other policy initiatives based on partnerships and participation is explored next.

2.2.2.1 Health

The Blair government was intent on removing the remaining obstacles to joint working between health and social services and integrated health and social care provision (Dept of Health, 1998b). However the legislation that allowed joint health and social care commissioning bodies left their development to local arrangements between health and social services (Health and Social Care Act 2001). Councils were encouraged to include direct payments in their joint strategies and to think imaginatively '*... about how direct payments can be assimilated into preventive and rehabilitative strategies.*' (Dept. of Health 2000a, 3.).

Research supported the use of direct payments for integrated health and social care packages, to extend user choice (Maglajlic, Brandon and Given 2000, Glendinning and colleagues 2000a). Nevertheless the use of direct payments for health care continued to be unlawful in New

Labour's initial policy guidance (Dept of Health 2000a). This meant potential problems for the practitioner responsible for assessing individual needs holistically and for the user responsible for managing a pure social care budget and package within an integrated care plan (Glendinning 2000a). There appeared to be a continuing reluctance on the part of the Blair administration to put a price on health care need at the point of delivery. This may be accounted for through Cutler and Waine's (1997) analysis of the special protection given to health services from the discipline of market forces, within the contract culture of the Conservative government's social policy.

The requirement to distinguish between individuals' health and social care needs, within integrated community care packages, had implications for implementation during the first three years of New Labour's efforts to extend the role of direct payments in community care. This was despite the Department of Health's (1998a, 2) criticism of the system in need of reform ;

'...sometimes various agencies put more effort into arguing with one another than into looking after people in need....Everyone needs to be treated as an individual and have the system geared to their needs and not vice versa.'

New Labour renewed its commitment to ensure that health services were available to all on the basis of need rather than ability to pay (The Labour Party 2001, Blair 2001b). However it promoted the development of clear eligibility criteria and means tested charging policies by local social services departments (Dept of Health 2002a). Health care continued to be based on the universal principles that underpinned the foundation of the National Health Service, despite the increasing but 'pragmatic' use of the private sector. Social care in contrast was still delivered selectively to those who could not afford to make their own provision. It was thus based on a residual rather than a rights- based model of welfare. The evidence from research and consultation with user organisations eventually led to a relaxing of the prohibition against the use of direct payments for health care (Dept of Health 2002b). However practitioners would be required to continue to draw a distinction for charging purposes.

The integrative potential of a taxation-funded service, used by almost, everyone was identified by Titmuss (1974). Users and practitioners in health care do not endure the stigma and 'discourse of failure' (Langan 2000) endured by personal social services clients and staff.

'While attempts to develop alternative welfare strategies based on social divisions of a non-class nature (which reject the need for state collectivism) are not without merit, there is a real risk that disengagement from the defence and promotion of progressive forms of state welfarism, will lead to an increased level of inequality.' (Page 2001, 515)

2.2.2.2 Carers

The New Left critique of the welfare state and the Conservative governments' 'reforms', included research into 'informal care' particularly from a feminist standpoint. Williams (2001)

observed that the concept of care as oppressed labour and the political demands for the recognition of carers were central to the early work. From the eighties attention shifted to an interest in and celebration of the meanings of care for women, but these studies were limited in their gender focus.

It was perhaps in the exclusion of payments to relatives that one of the apparent contradictions in New Labour's social policy could be perceived. It appeared that New Labour was in favour of giving 'the unsung heroes of British life' (Prescott 1999) every support, apart from payment for their services. The value of carers' labour was estimated at £34 billion annually (Wellard 1999). This restriction on user choice was not consistent with market theory or the practice in other European welfare systems with more established traditions of direct payments. It was nevertheless supported by the National Centre for Independent Living⁶. Their concern about distorting the nature of 'informal' relationships and diverting attention from the needs of disabled people themselves, reflected the tensions in constructing 'care' as a commodity within the market place of the 'community'. This restriction acknowledged the potential power imbalance between users and carers, revealed by research into efforts to engage users in the development, and management of services (Barnes and Wistow 1994, Servian 1996). The Carers and Disabled Children's Act (2000) gave councils the power to make direct payments to carers to purchase services to meet their own needs for 'support' to continue caring. Councils were required to distinguish between the assessed need of the user, from that of the carer, to make respective payments from available resources.

Carers were therefore constructed as a quasi-client group in the Blair government's social policy programme (Lloyd 2000). The provision of support for those who care, to enable them to continuing caring at little cost to the public purse, represented a cost-effective strategy consistent with a 'modern' or third way approach to combining public and private resources. This offered particularly good value because New Labour's policy on charging for community care services encouraged councils to require carers to contribute to the cost of any support they receive.

The concept of an 'ideology of caring' was exposed by Morris (1993) as another source of oppression of disabled people. She criticised feminist writers who, in decrying the situation of female informal carers, ignored the experience of disabled women. A focus on partners and relatives justified the under funding of the support that disabled people themselves need to live as equal citizens. It also compounded the misrepresentation of abled-bodied people as uniquely self reliant, by denying the reality of interdependence and reciprocity that exists in informal

⁶A major campaigning organisation run by and for disabled people and funded by the government to assist with the development of direct payments.

relationships. Empirical support for Morris's argument was provided by Walmsley's (1993) research. She found that it was frequently impossible to draw a distinction between 'carer' and 'dependent', because in the relationship both parties give and receive. However in the ideology of caring, disabled people are not just a burden on society but a burden on their families. New Labour therefore recognised this by requiring councils to offer carers support to continue with the tasks of caring, ideally while participating in the labour market.

'There exists a fundamental tension between the practical acknowledgement of care and the political privileging of the labour market.' (Williams 2001, 474)

2.2.2.3 Users

The centrality of users to the implementation of direct payments exemplifies some of the tensions identified in the literature on New Labour's programme, as well as the issue of the prioritising of economic objectives as a prerequisite of achieving social goals. Taylor-Gooby (1999) argued that New Labour's approach, in relying on individuals pursuing their own self interest for the efficient allocation of resources through a market mechanism, was consistent with the conceptual framework of 'instrumental rationality', dominant in the Conservative governments' social policy. This was illustrated by the revised guidance on direct payments (Dept of Health 2000a, para. 3).

Alternative models of user involvement and motivation were identified by research as underpinning the direct payment schemes developed in Conservative and Labour led authorities before 1997, that is 'individual' versus 'collective' (Priestley 1999). Research by Pearson (2000) also contrasted the influence of either a 'market' or 'social justice' discourse on the implementation of direct payments in other authorities, similarly distinguished by 'right' or 'left' party political control. In the Conservative authority, users were subject to rigorous monitoring procedures, which undermined the liberating potential of direct payments. In the Labour authority direct payments were not offered to day service users because they threatened public sector jobs.

Disabled people were coming together to campaign for 'inclusion' in the normal life of society, to take control of their own lives and to challenge the 'expert' status of professional knowledge before the conceptualisation of the user as consumer. Barnes' (1997) research revealed that the experience of collective action has been, of itself, a means of empowering and encouraging the participation of previously excluded people as 'active citizens'. Direct payments to users introduced the potential for increasing the competitive individualism amongst these paying customers, to create the conditions in which a market in social care can thrive. Barnes suggested that this development could be to the disadvantage of some people. Those least able to negotiate the role of employer, those whose support needs are not related to physical assistance and those

who already suffer greater exclusion than other community care 'users' because of their legal status would be disadvantaged. Barnes' arguments are relevant to the analyses of Greener (2002), Hoggett (2001) and Taylor-Gooby (2001) discussed above (2.2.1).

There are tensions within the conceptualisation of the responsible citizen and the model of the informed individual consumer. The former actively participates in democracy and calls politicians and public servants to account, the latter engages in market exchanges in pursuit of self interest to optimise personal 'welfare' through 'trading off' cost and quality considerations. These tensions are illustrated by Barnes' (1997) work. Writing about what they constructed as the ideological basis for involving users in community care development under the Conservative governments of the 1990s, Croft and Beresford (1990) suggested that the 'consumerist' approach begins with the service providers' needs while the 'democratic' approach is essentially citizen- led. Dividing and transforming dis-empowered users into consumers will not overcome their oppression because the politics of liberation do not necessarily sit easily with those of the market place.

The consumerism of the Major years allowed services to be less accountable according to research reported by Cowen (1998). This suggested that the separation of users from each other and from providers in a market place, together with a spirit of entrepreneurialism, would not encourage user participation. The achievements of 'communities of interest' as well as very local community groups, described in the literature on social inclusion and participation, could be problematic because of the fundamental tension between the principles of competition and co-operation.

The ownership and control of social policy, as both a political process and an academic discipline, play a key role in determining its regressive or liberatory potential argued Beresford (2001,495). The emergence of service users and their movements as new participants in social policy began to impact on the provider -led policy and provision, where developments were the result of negotiations among interest groups in the local and central state. The 'rhetoric of empowerment' was discussed by Shaw (1997), who suggested that the participation and involvement of users is often restricted to the 'micro-level' of individual influence on the actions of front line workers with little impact on policy or decision making. However in one important analysis to be discussed in the next chapter (Lipsky 1980), it is at the 'micro' level of interaction between individual users/ citizens and public sector workers that crucial policy decisions are actually made. Nevertheless, the amount of influence the individual user can exert over the outcome of those decision-making processes will be affected by his or her social status (Lipsky 1980) or symbolic capital (Greener 2001).

2.2.2.4. Communities

The ideal of active citizenship is found in the traditions of Aristotle and Rousseau. Full membership of a political community implies an exclusive system of co-operation, in which members contribute to the common good and refrain from mutually harmful conflict. Jordan (1999) argues that the 'exclusivity' of the association is based on the principles of contribution and collective responsibility. Much of the appeal of communitarianism, for New Labour appeared to be in its assertion of the need to re-establish the connections between individual choice and collective responsibility. The seminal essay of T.H. Marshall (1992,8) described the building up of the rights granted by the state to the individual through legal then political to social rights in the creation of the 'welfare state'. The communitarian value base offers support for the third tier of social rights in the altered economic, political and social landscape fifty years on. With 'New Labour' the link was emphasised between the individual's responsibilities and inclusion in the 'exclusive association' from which s/he is granted social rights to 'welfare':

'A responsibility from us all to provide help; a responsibility on us all to use that help to help ourselves.' (Blair 2000a, 5)

Principles of co-operation again conflict with the concept of the 'invisible hand' steering individuals towards the fullest realisation of their preferences, through competition. Jordan (1999) maintains that current political thought is characterised by 'muddles' including the 'confusion' between the interactional code of reciprocity and the market place rules of fair exchange. The former relies on the bonds of personal obligation as characterised by interpersonal relationships between family members, neighbours and friends. These bonds are absent in market transactions, where resources can be allocated efficiently without reference to sentiment. The attempt to exclude relatives from payment for providing care in New Labour's social policy recognised this distinction identified by Jordan, which seems blurred elsewhere in the often vague notion of the 'community' as a source of 'care'. The 'muddle' continued with the extrapolation from intimate associations to large scale impersonal ones. Jordan challenged the idea that labour contributions are an efficient means of eliminating 'free riding' in the latter. The conditions conducive to effective use of moral sanction, face-to-face contacts, are absent so coercion is required. Ellison (1998) also identified the potential threat of coercion in the prioritisation of economic objectives in welfare policies.

2.3. The Labour Market, Social Inclusion and Citizenship

In the new orthodoxy, associated with Blair's Government, social justice and economic efficiency could be reconciled. A focus on the labour market in the design of social institutions was intended to provide a culture of opportunity and employability for all citizens. In the U.K.'s official definition of social exclusion the emphasis was on unemployment and low incomes, and did not include the absence of interpersonal relationships, which characterised European definitions. The British research tradition has concerned itself with the distributional aspects of

social exclusion (with the exception of Townsend's (1979) work, acknowledged by the European Commission 1993). Direct payments were identified as having an important role to play in enabling disabled people and carers to work, contribute economically and in so doing become 'included' (Dept of Health 2000a). Nevertheless commentators like Hutton (1995) have discussed both the relational and the distributional aspects of exclusion and their complex and compounding effects. Combating exclusion is not just about economic involvement and contribution, but has social and inter- relational dimensions.

Users coming together for collective purposes might fulfil obligations of citizenship (Prior and colleagues 1995), consistent with the classical notion of the citizen as public actor. However official discussions of direct payments under New Labour emphasised issues of individual control, increasing independence, responsibility and work incentives rather than opportunities for participation, collective action and interpersonal development. Research describing opportunities taken by users to contribute to the planning and management of services, to the training of professionals and the education of the wider public, was collated by Barnes and Warren (1999). These experiences have advanced users' own personal and 'community' development and have been identified in collective action and the new culture of participation in welfare services. Both Barnes (1997) and Cowen (1998) expressed concern that those opportunities may be lost in consumerist policies and market- oriented strategies, which divide users and individualise their problems and the potential solutions.

'The messianic promotion of paid work as the salvation of all and as the key to social inclusion and citizenship responsibility... is seen by many as devaluing unpaid work in the home and the community.' (Lister 2001, 439)

There are recipients of welfare who can not hope to win the right to 'inclusion' through the labour market, because of illness, age, frailty, impairment or caring responsibilities. The prioritisation of paid employment over all other roles as a means through which citizenship can be expressed and experienced denies the value of other types of contributions and excludes those for whom 'work' is not an option.

2.3. Conclusion: Direct Payment Users, Consumers or Citizens?

Direct payments are an example of an ideal 'third way' policy because in principle they cannot be done 'to' the individuals but require active co-operation (Dept of Health 2000a). The nature of that active co-operation is contested.

'Consuming... communicates an entirely different outcome than ... participation as a producer. There is a striking parallel between consumers of services and consumers of commodities: both are out of control of what they consume; both stand outside the determinants of the process of production; both act in response to a definition of their needs outside of their conscious control; and both are recipients of the interaction which reproduces existing power relations..' (Rose and Black 1985, 37)

Disabled people, including people with learning difficulties or mental health problems and the frail elderly have demonstrated that they have experience and expertise to offer to service development and the potential to contribute to the life of the community (Barnes and Warren 1999). The distinction drawn by Beresford and Croft (1993) between a consumerist model of participation and a democratic model can be explored through the example of direct payment schemes. They suggested that consumerism in social care accompanies the ideology of welfare markets in which needs and services are commodities to be traded and regulated through the forces of supply and demand. Through the exercise of consumer power, services may become more responsive to end user preference but remain owned and controlled by the organisation and professional providers. The limitations on the exercise of power by 'consumers' in welfare markets include inequality in the distribution of resources, status and political power in society generally. These are compounded in community care by the control exerted by local eligibility criteria, budget constraints and professional dominance of the assessment and care planning processes, along with uneven access to information. In contrast the democratic model of participation extends the influence of users to policy making, resource allocation and the development and management of services. Exercise of power in these spheres means reconceptualising the user as a citizen. However this implies a rights rather than a needs based model of involvement in services and recognition of the damaging effects of oppression and exclusion on individuals and social groups, if the ideal of active citizenship is to be realised.

The implementation of the Blair government's instruction to councils to involve users in the development of direct payment schemes can be analysed using Arnstein's (1971) model of the ladder of power- sharing. The rungs on the ladder descend from citizen control, through delegated power, partnership, placation, consultation, information and therapy to manipulation. Priestley's research (1999) showed how a group of disabled people, asserting their rights as citizens collectively, won funding from a Labour council to develop and manage a personal assistance scheme. In Priestley's study this example of collective control of a service, by disabled people, was threatened by the implementation of the Conservative government's community care policy. The impact of the ideology of welfare markets, contracts and competition for scarce resources threatened to change the nature of user involvement, from collective control to individual consumerism.

A study of several councils' attempt to engage citizen participation in the piloting of New Labour initiatives, by Martin and Boaz (2000), drew a distinction between user-focused and user- led services. The former approach was akin to the consumerism promoted by Conservative governments. The latter offered local people an active role in the design and delivery of services. They also found an uneven distribution of '*capacity and appetite for participation*', with people at greatest risk of social exclusion least inclined to active engagement (51). The

work of Taylor-Gooby (2001), Hoggett (2001) and Greener (2002), suggested that opportunities to participate and take greater individual and social responsibility in the context of 'community care' may not equally distributed because of the reality of differences in experience and expectation. Barron (2001) found that the granting of 'rights' to disabled people in Sweden operated as a mechanism for both 'inclusion' and 'exclusion' depending on the social situation and the nature of the relationships experienced by the individuals interviewed. For those able to assert their rights to have choice and control over the personal assistance they required, the reform meant greater autonomy and participation. For others, specified individual rights had little bearing on their lives or on their ability to secure the support they needed.

Involvement in the planning, development and delivery of direct payments appears to offer one way that disabled people at risk of exclusion can be given the opportunity to contribute through public service and the exercise of both the rights and duties of citizenship. However this depends on how far politicians and professionals are willing to seek and support their participation.

In this chapter the debate about the history of the development of direct payments has been outlined. Their introduction was examined as a 'consumerist strategy' within the market oriented community care policy of the last Conservative government. The roots of direct payments in the struggles of disabled people for independence were exposed. Alternative views on whether the original empowering objectives were being achieved or compromised by Major's approach were discussed. The relevance and role of the extension of direct payments as a 'third way' initiative within the Blair government's policy programme and possible implications for implementation were outlined. The policy implementation literature will be discussed next, followed by the context for the implementation of the particular initiative. This includes the changing roles of social workers, the tensions between professional and organisational cultures in the implementation of community care policy and their implications for the promotion or obstruction of individual and collective participation through direct payments

CHAPTER THREE

Direct Payments as a Case Study in Policy Implementation

'Government either seems unable to put its policy into effect as intended, or finds that its interventions and actions have unexpected or counter-productive outcomes.' (Barret and Fudge 1981, 3)

3.0 Introduction

In chapter one the literature on New Labour's policy approach and its claims to be following a non-ideologically based 'third way' in pursuit of its objectives was discussed. The third way renounced both the last Conservative government's confidence in laissez-faire individualism and previous Labour governments' commitment to collective purposes and provision, in favour of a pragmatic use of the market as a means rather than an end. In chapter two the current government's approach to 'direct payments', as an initiative with characteristics typical of the 'third way', was introduced. The debate in the literature about whether direct payments had originated as another 'consumerist' strategy within the Conservative government's community care policy or whether it had been an initiative with genuine empowering potential, was explored and consideration was given to research that identified how the nature and outcomes of direct payment schemes in different local authorities had been influenced by the ideological positions of their political leaders (Pearson 2000, Priestley 1999). Alternative models had advantages and weaknesses in achieving the various objectives ascribed to direct payments. New Labour presented the third way as a pragmatic approach with the potential to overcome the disadvantages of polarised ideologically based initiatives. This chapter discusses the literature on policy implementation and examines research that reveals the gaps between the objectives and outcomes of community care policy and the contribution of social workers, as care managers.

Blair's government recognised the weaknesses of previous administrations' approach to ensuring policy effectiveness:

'One big trouble social services have suffered from is that up to now no Government has spelled out exactly what people can expect or what the staff are expected to do. Nor have any clear standards of performance been laid down. This Government is to change all that.' Frank Dobson, Secretary of State, in the introduction to *Modernising Social Services* (Dept of Health 1998a i)

3.1 The Gap between Policy Intentions and Outcomes

The literature recognised that the intentions of policy-makers are not always achieved in policy outcomes. The concept of the 'implementation gap' was identified by Dunsire (1976). He explained that the inability of governments to achieve their policy intentions can create demands for further policy change. Dunsire's conclusions seem relevant to the discussion in *'Modernising Social Services'* about the failure of Conservative governments to achieve the objectives of 'community care' policy, through the organisational and cultural changes initiated

in social services (Dept of Health 1998a ch.1). The policy itself was not challenged. Instead the Conservative governments' lack of clarity in setting objectives and standards and providing consistency across its overall policy framework was highlighted. Deficiencies in leadership and direction at the policy making level (along with a dogmatic commitment to privatisation) were blamed for the implementation failures of social services.

The literature challenges the assumption that central decision-makers are the key actors in the policy process. Hjern (1982) identified 'policy sub-systems' arguing that it is inadequate to use 'top down' approaches to implementation research because they neglect the strategies of public servants to divert policy to their own ends. He found no real distinction between policy formation and implementation. Hjern and Porter (1997) advocated a 'bottom-up' approach to understanding policy action, exploring the network of actors and agencies involved. While conceding many of the criticisms of top down approaches, Sabatier (1997) warned that blurring the distinction between policy making and implementation makes it difficult to distinguish the relative influence of elected officials (democratic accountability) and public servants (bureaucratic discretion). Identification of decision points facilitates both policy evaluation and analysis of policy change. The decisions of national politicians are important, that is why interest groups try to influence them.

Recent policy research in Britain appears to have been largely based on the concerns of central government with securing compliance with its objectives. Schwandt (1997) suggested that evaluation in this context assumes that policy is linear, reasoned and purposive action directed towards clear goals. It is situated within a 'modernist paradigm', within which rationality is a matter of correct procedure. An emphasis on method rather than theory as the basis of evaluation has been encouraged alongside concern with defining intended outcomes in measurable ways. Less attention has been given to explaining the links and interactions between policy interventions and the cumulative impact of policy change. The motivation of individual actors and the influence of institutional regimes should not be neglected because policies are usually underpinned by theories of how both can be changed (for example that market discipline would lead to greater efficiency in public services). Sanderson (2000) described how a renewed focus on the role of institutions in mediating policy implementation has emphasised the complexity of policy systems.

It is particularly difficult to distinguish between the policy making and implementation processes, where discretionary powers are given by one tier of government to another in furtherance of its objectives (Hill 1981). Alternative approaches taken by Labour and Conservative controlled councils to their duties under community care policy, illustrated how ideological differences between central and local government can affect the implementation

process. Three 'elements' of the policy action relationship were distinguished by Barret and Fudge (1981,7): the environmental system from which demand arises; the political system in which decisions are made and the organisational system through which policy is mediated and executed. Within community care policy each of these 'elements' represented a complex interaction of national and local issues, interests and constraints. The introduction and extension of direct payments in the U.K. reflected a broad range of influences and the interests. The aims of the policy, and the appropriate means of achieving them, have been debated. Direct payments can be constructed within alternative 'discourses', can be developed from apparently opposing value bases and attract both the support and resistance of a variety of interests involved in implementation. These tensions can be manifest in each of the three elements of the policy action relationship.

Local authority powers to make direct payments entered the statute book as The Community Care (Direct Payments) Act. The parentheses clarify the subordinate position of one policy initiative to the other. The history of direct payments as an aspiration of the disabled peoples' movement preceded the introduction of the Thatcher / Major version of 'community care'. However it was in the environmental, political and organisational landscape created by the 1990 National Health Service and Community Care Act that councils were permitted to make direct payments. Therefore the implementation process occurred in that context. Research into the impact of the introduction of a 'mixed-economy', to be discussed next (3.1.1.), suggested that some of the overt objectives of community care policy were undermined rather than promoted by the use of 'market' devices.

3.1.1. Markets in community care: the objectives and outcomes of policy

New Labour advocated the use of the market as a pragmatic means to achieve the objectives of social policy rather than as an ideological end in itself (Dept of Health 1998a). The strategy was apparently based on the premise of neo-classical economic theory that the market is the efficient means of allocating scarce resources to optimise the benefit or 'welfare' to be derived from them. Individuals competing freely in pursuit of their own self-interest will ensure that goods and services are provided at the most satisfactory quantity, quality and price.

'It is not from the benevolence of the butcher, the brewer or the baker that we expect our dinner, but from their regard to their own self interest.' (Smith 1961, 15)

Purchasers are expected to balance price and quality considerations, choosing the amount of each good to be purchased on the basis of the amount of 'utility' it confers. The model assumes that the purchaser has immense capabilities in the collecting and processing of information necessary to make a choice.

The weaknesses of 'quasi-markets' in public services were identified (Flynn 1999, Le Grand 1993, Bartlett 1998). They lacked the 'conditions for success' prescribed by neo-classical economic theory, largely because the public servants who managed purchasing budgets and contracted for services were not the people who need the services or experience how they are delivered. Quasi-markets were characterised by potential principal-agent conflict because the interests of professional decision-makers (agents) are not the same as their clients/service users (principals). Efficient resource allocation was limited by information asymmetry, between bureaucratic purchasers and service providers, with distant purchasers unable to judge the quality of and need for the service provided. There were opportunities for moral hazard (for example providing poorer quality services than specified in the contract) and 'cream skinning' (choosing the least costly users). There were also potential market entry problems. These characteristics were found in studies of particular community care markets and the behaviour of social services staff (Knapp, Hardy and Forder 2001, Lapsley and Llewellyn 1998, Mannion and Smith 1998, Taylor-Gooby 1999).

The production of care is interactive. It is produced and consumed simultaneously and involves intimacies between producer and consumer not generally associated with the market place (Twigg 1997, Henwood 1998, 2001). Welfare services also have public as well as private good characteristics (that is they provide social benefits), which cost and quality 'trade-offs', based on the preferences of individual users or priorities of particular budget holders, may not address. Unlike central purchasers, the practitioner 'care managers' observed by Knapp and colleagues (2001) were well placed to identify and respond to individual needs and preferences. They required time, information, skill, autonomy, devolved spending power and incentives to commission cost effectively. However care managers were not budget holders or part of a purchasing team in most authorities studied. Knapp and colleagues concluded that despite the trend to concentration of social care provision in a reducing number of providers, the biggest threat to free competition (that 'text book' economics suggests is the key to efficient resource allocation) is the monopsonistic power wielded by dominant local authority purchasers.

Economic psychology suggests that the assumption that actors in welfare markets are motivated by the instrumental rationality, upon which market theory is based, is not necessarily valid (Taylor-Gooby 1999). Mannion and Smith (1998) drew on the account offered by economic sociology, in their study of community care purchasing decisions. This stressed that economic decisions are taken within a social setting and so choices could not be understood in isolation from the setting in which they occur. Social relations between the actors involved and their social networks were important. Front line practitioners were central to the purchasing decision-making in all the authorities Mannion and Smith (1998) studied, although Knapp (2001) found that were rarely budget holders. Rather than 'trading-off' cost and quality as in the neo-classical

model, care managers were unwilling to accept reduced 'quality' as compensation for lower prices. Mannion and Smith attributed this partly to the conflict between the professional ethos of the typical practitioner and the managerial ethic on which the market reforms were based. Also relevant were the care manager's private goals (job preservation and career advancement) which may have conflicted with the interests of users but which were likely to make her, in terms of economic theory, 'risk averse'. Banks' (2002) research suggested that the tendency to risk aversion is increasing. Mannion and Smith found that budget pressures meant that scarce resources were directed to those with highest care needs, to the detriment of other people, whose longer term independence might have been promoted by cheaper care packages with a preventative focus. This outcome of market discipline and cash limited budgets was therefore in conflict with the wider policy objectives, including achieving 'value for money' (D.H.S.S. 1989) or in New Labour parlance 'best value' (D.E.T.R. 1998). Blair's government criticised this pattern of rationing scarce resources, which had become widespread, in the face of budget constraints. The use of increasingly stringent eligibility criteria for community care diverted resources from short term interventions focussed on prevention and rehabilitation, that is from promoting independence at the risk of prolonging dependence (Dept. of Health 1998a, 2.6).

'Quality' was perceived as an elusive concept in the community care markets studied by Mannion and Smith (1998), while price was generally unambiguous. They found that purchasers frequently invoked 'colloquial' and 'common sense' notions of quality as decision-making criteria. However they relied largely on informal information, status, trust and reputation to determine which provider was awarded the contract. New Labour's approach to the mixed economy of care promoted the development of partnerships between statutory and independent sector agencies, encouraging collaboration rather than competition (Dept of Health 2001c). Knapp and colleagues (2001) found that relationships based on trust between local authority commissioners and independent sector providers were only beginning to develop.

An 'ethic of trust' was identified as a valuable legacy from the traditional welfare state to the new mixed economy by Taylor-Gooby (1999). Similarly Lyons and Mehta (1997) asserted that policy-makers should be aware of the interdependence and continuing interplay between organisational structures and agents. Trust is unstable and susceptible to manipulation; policy pressures can undermine traditional patterns and disrupt long-term relationships. Given the reliance on trust by agent-purchasers revealed by their study, Mannion and Smith (1998) questioned whether, despite policy objectives, community-care markets could ever be truly competitive.

Trust sounds like a 'good' thing. Trust between the public and private sectors may reduce the 'transaction costs' of both specifying and policing contracts. However the objective of efficient

resource allocation through the market may not be achieved by 'collaboration'. Resources are wasted if purchasers use proxies for quality that are irrelevant to users, if providers avoid delivering to the standards and amount required and if both collude in ways that do not satisfy user needs and preferences. For efficiency, the priorities and concerns of individuals who use the services should be reflected in the contract requirements and users should be involved in the monitoring of their delivery.

Social service purchasers took little interest in detailed cost information in Lapsley and Llewellyn's (1998) research. They took the level of wages as an indicator of quality and focussed on the aspects of care delivery concerned with social work 'clan values', expressed as client choice, dignity, needs and preference. Senior managers were reluctant to delegate budget control to practitioners to avoid compromising the traditional social work values of client advocacy and intruding on the casework relationship. The exploration of older people's views carried out by Henwood (1998) however revealed a consensus and clarity about the components of a 'quality' domiciliary care service, lacking amongst professionals. These components featured the users' experience of the process of service delivery and interaction with care staff, rather than the financial stability and policies and procedures of the organisation that concern council contracts officers. The consultation exercise reported by Turner (2000), the views of different groups of service users highlighted by Harding and Beresford (1996) and the Raynes' (2001) survey of older peoples' aspirations, yielded similar conclusions.

It therefore seems that 'principals' (users) do not perceive the issue of quality to be the vague and elusive concept that 'agents' (care managers) in the community care market do. Research has consistently highlighted high levels of satisfaction amongst the users of direct payments, from the early study by Zarb and Nadash (1994) to the more recent work of Dawson, Glendinning, Magliajic, Pearson and Witcher (all published in 2000), Evans and Carmichael (2002). These studies have all shown that people choosing 'cash for care' have achieved those components of a quality service identified by users in the above studies, by managing their own care arrangements. The research on community care markets has implications for the implementation of direct payments. It suggested that users may be more able and willing to trade off price and quality in a utility function than their 'agents' the social service purchasers, for example to decide they would benefit more from less hours of service of higher quality or vice versa. However not all councils allowed users to exercise that particular choice and instead specified in detail how the direct payment must be spent.

Following the above discussion about the difficulties in realising policy objectives through market mechanisms, the implications of the literature for another aspect of the Blair

government's approach to securing policy outcomes, centralised performance management will be considered..

3.1.2. The Limitations of Political and Management Control

'A huge industry has been created around targets, performance indicators and performance management systems all of which are derived from a mistrust of managers and professionals.' (Hunter 2001, 57)

The inability of 'top level' actors to control the actions of lower level actors has been explained only partially by the tensions between central and local politicians working from different value bases (Pearson 2000, Priestley 1999). Williamson (1975) used the concept of 'bounded rationality' to explain how the control exercised by actors in positions of authority in complex organisations was limited by their information processing capacities. Lindblom and Woodhouse (1993) endorsed this with reference to public policy. Johnson (1975) studied a U.S. social work agency in a policy context where the Federal and state governments were trying to control the behaviour of public welfare organisations. He found that their efforts were often ineffective and sometimes counter-productive. Thus Hudson (1989, 386) suggested

'the broad problem confronting policy-makers is that policy is rarely applied directly to the external world, but is mediated through other institutions and actors. Policy impact is therefore at risk of distortion by these mediators'

The collective term 'street level bureaucrats' was developed by Lipsky (1980). Public servants, who directly interact with individual citizens, often exercise substantial discretion in carrying out their duties. The concept encompasses a broad range of public servants but is particularly relevant to the role of social services practitioners. Lipsky suggested that the poorer people are the greater the power exercised over them by 'street level bureaucrats', because the delegation of responsibility for addressing irremediable social problems, through practitioner discretion, serves the interests of politicians.

'Through street level bureaucracies the society organises the control, restriction and maintenance of relatively powerless groups. Antagonism is directed towards the agents of social services and control and away from the political forces that ultimately account for the distribution of social and material values.' (Lipsky 1980, 191)

The concept of street level bureaucracy is relevant to contemporary U.K. social work where direct work with clients is not subject to outside scrutiny or managerial control (Myers and McDonald, 1996). Wells (1997, 333) described how mental health practitioners expect autonomy in their work and managers have to achieve outcomes and manage resources within a complex and sometimes contradictory policy context. They may therefore try to influence but not direct practice. *'...managers and policy makers may have a vested interest in not scrutinizing practitioners' implementation of policy too vigorously as a way of deflecting responsibility for*

its consequences.' The character of client treatment by street level bureaucrats reflected and reinforced class and ethnic divisions in Lipsky's work. Research in Britain showed that black people were not only over-represented in mental health services, but were more likely to be identified as 'dangerous' and so subject to greater controls through the 'Care Programme Approach' than white people (Rose 2001). Social disadvantage was compounded by professional judgement. With regard to direct payments, differential expectations and consequent treatment of particular user groups may influence their experiences.

Community care services are provided selectively by local authorities for those not affluent enough to make their own arrangements based on practitioners' assessments and interpretations of eligibility criteria (1948 National Assistance Act, Dept of Health 2002a). Interactions between social workers and clients, during the assessment process, were observed by Stanley (1999). She concluded that the culture of community care embodied 'consumer choice' rather than 'user choice', with those able to express their needs forcefully exercising more 'choice' than those who could not. A direct payment may be presented and perceived as no more than another 'option' in the range of packages on offer to meet care needs, or as an opportunity for self determination and empowerment. Taylor-Gooby's (2001) empirical testing of the 'risk society thesis' suggests that people from more privileged circumstances perceive increased choice positively where those less privileged perceive it more negatively. Therefore, whether or however the choice is offered, those on the receiving end of this extra option may perceive it as a threat rather than an opportunity. This supports Lipsky's account of the power wielded by street level bureaucrats and the importance of the interaction between citizen and public servant in policy implementation.

There are variations in the 'take-up' of direct payments between local authorities, user groups and the case- loads of individual social workers within a particular area (Bright and Drake 1999, Ryan 1999, Valios 2000, Witcher and colleagues 2000). Access to information has been identified as crucial to the success of particular initiatives, in both the literature on markets (Le Grand and Bartlett 1993) and empowerment (Maglajic 2000, Servian 1996). Bewley (2000) and Evans and Carmichael (2002) have described the key role of practitioners in promoting direct payments, alongside that of well-organised and informed user interest groups identified by other researchers (Maglajilic and colleagues 2000, Hasler 1999, Priestley 1999). The Social Services Inspectorate's research (2000) associated care management staffs' ambivalence and lack of knowledge with low take up of direct payments. Witcher and colleagues's (2000) survey of direct payment schemes in Scotland and Dawson's (2000) evaluation of the Norfolk pilot scheme confirmed the importance of social workers as 'gatekeepers' for direct payments. Dawson also identified the support and time commitment of senior staff as significant.

The actions of practitioners further down the organisational hierarchy may be even more influential than that of managers and professionals, for some users. Care staff develop relationships with people receiving domiciliary, day and even respite services. Pearson (2000) found that in a Labour controlled authority, users of council services were denied access to direct payments, which were promoted for others, because of the perceived threat to public sector jobs. Brandon and Brandon (2002) provided socio-organisational analysis of services used by disabled people. This exposed how 'service forum incoherency' arises from a disparity between the 'posture' of the organisation (authority structures and goals) and its (informal) culture. The latter can mould staff into working practices that conflict with official objectives.

'Consumerism' in social care was distinguished from 'empowerment' by Jordan (2000). With consumerism users are allowed to choose between pre-selected or off the shelf care packages not tailored to individual needs and preferences. Empowerment means the user is central to the design and development of the package. The responsibility and judgement exercised by councils and social workers, in facilitating access to direct payments, could crucially influence whether they are limited to extending consumer choice or whether their empowering potential is realised, through enhancing the individual's control and self determination.

Centralised performance management systems set criteria against which a public service's performance in the achievement of policy objectives is judged. The strong leadership and clear direction promised in the White Paper (Dept of Health 1998a) may not be enough to secure success so defined. Personal interests and attitudes, professional values, occupational allegiances and organisational cultures all have a part to play in the realisation of official goals. In addition, public servants may have opinions and beliefs that support or reject the ideology they perceive as underpinning the policies they are expected to implement.

3.1.3. Public service staff and New Labour's social policies

The interests of public sector workers were conventionally perceived as best served by Labour governments. However Blair (1999) attributed resistance to his policy programme to the persistent forces of conservatism amongst public sector workers. He distinguished '*small c conservatives*' from those co-operating with reform in public services (Blair 2002a, 5). Nevertheless the implementation of the policy of extending direct payments was left to social services departments, through the care management function of individual practitioners.

Early in its second term Blair's government announced its intention to extend the role of the private sector in the management and delivery of public services (Queen's Speech 2001). Blair's (2001c, 4) speech for the T.U.C. conference was intended to defuse the opposition of organised labour to his latest round of 'third way' reforms. '*Public services are the clearest symbol of*

community, solidarity, what we provide together as a society. For millions, they are social justice made real.'. He omitted to mention the personal social services in his roll of honour of valued public services, or the role of social care in meeting individual or community needs.

The resistance Blair perceived amongst public sector staff could be accounted for by their failure to accept the 'new individualism' of the third way approach to social policy. A comparative survey of public servants' views on the role of the welfare state and structural inequalities showed that salaried staff endorsed 'Old Labour' type welfare policies directed at systematic structural divisions in society (Taylor-Gooby 2000). From a 'collectivist' perspective the empowering qualities of consumerist devices like direct payments to individuals may be limited or undermined by their experience of structural inequality, social deprivation and division. The findings of Barron's (2001) research in Sweden were that an ideological shift in focus from equality and solidarity to freedom of choice benefited some disabled people but was to the detriment of others. Therefore, support for or opposition to direct payments amongst social service staff may warrant a fuller account than the self-interest motivating the 'knaves' who receive and provide contemporary welfare services, discussed in Le Grand's (1997) analysis of changing perceptions of public service workers and users. The third way leaves public service practitioners facing dilemmas in reconciling the tensions between universal and selective welfare models through decisions made in their day-to-day work with individuals. These dilemmas are illustrated by the examples of charges for community care and the distinctions between health and social services.

The 1948 National Assistance Act repealed the Poor Law and placed a duty on councils to provide accommodation for people in need of care and attention because of age, illness or disability '*which is not otherwise available to them*' (Part III, S 21, Ss 1a). The principle was thus enshrined in law that while the National Health Service was there for all, publicly funded 'social care' was only for those who could not afford to make their own arrangements. However when the Blair government came to power in 1997 Britain had become the 'property owning democracy' of Thatcher's vision, with the majority of the electorate aspiring to own their own homes.

'A key problem politically has been the attempt to reconcile the much-lauded virtues of saving and inheritance with the desire of the treasury to access the value of owner occupied housing vacated by care home residents.' (Fimister 2000, 165)

Lawyers and social workers with roles in the charging system for care homes were surveyed by Bradley and colleagues (2000). Eighty per cent of care managers said they experienced ethical dilemmas in carrying out financial assessments on behalf of the local authority and two-thirds experience stress. In contrast lawyers, who focussed on the interests of their clients, experienced less conflict. The charging regulations for residential care were set by government and have

been applied since the 1948 Act. Nevertheless practitioners experienced the rules as unclear, and felt they lacked adequate training and support in administering them. Actors at all levels in the authorities studied, including politicians of different parties, acknowledged the potential for the exercise of discretion, inconsistency and disregarding charge avoidance.

The New Labour government recognised the unpopularity of a historically rooted charging system. Charges left older people ending their lives on means tested benefits, after a life time's contribution through taxation and service, while depriving their children of their expected inheritance. However the recommendations made by the Royal Commission, that personal care should be provided free, were not accepted for England (Sutherland 1999). Instead only the 'nursing' element of care received a rights based (non- means tested) subsidy. This, together with case law intended to clarify policy intentions for those responsible for implementation⁷, placed additional responsibilities on practitioners. As well as assessing the individual's ability to pay, they were obliged to judge whether the person receiving residential care should receive a subsidy because there was a nursing element to the service. Practitioners also assessed whether the level and intensity of the care provided was such that it met the 'continuing care' criteria to trigger funding from the health service. These decisions were made within the context of local financial limitations, rationing devices and direct accountability to budget holders.

The level of discretion allowed in charging policies for non-residential services was much greater, as councils were empowered to introduce their own rules and rates for user contributions. Charges increased dramatically in the 1990s, along with their importance to community care budgets, funding twelve per cent of costs in 2000 compared with eight per cent in 1993/94. In 1992/3, 72% of councils charged for domiciliary care with the highest charge at £15 per week. By 2000 half the authorities imposed a weekly charge on some users of over £50 (Wright 2000). Reports by the Audit Commission (1999, 2000) revealed wide variation in the level and rules of charging across authorities and complexity and confusion leading to inconsistency in practice within them. Some users, including people living on income support, were being subject to multiple charging systems for different services. The Blair government introduced new guidance on charging for community care services (Dept of Health 2002a), as part of its 'Fair Access to Care' project and made income from earnings exempt from means tests. Councils retained significant discretion as to how far they choose to use their powers to exact contributions from users. It was 'front line' staff who continued to play a major part in implementing those policies. Furthermore the differences between the legal, political and financial significance of charges in health and social care persisted in New Labour's policy framework.

⁷ See R v N and E Devon Health Authority ex parte Coughlan 1999

With direct payments, the issue of user charges became more explicit. The conversion of the value of services into a cash sum, net of the assessed charge, highlighted the proportion of the costs of services being met by users. Over a decade of policy statements by successive governments espoused the objective of creating 'seamless' or fully integrated health and social care services in the community (D.H.S.S. 1989, Dept. of Health 1998a, Dept. of Health 2000b). However the economic imperative for councils to generate income through charges and the political imperative for the national government to ensure that health care was free at the point of demand (Bruce and Falconer 1999) continued.

Alternative charging rules, alongside variations in the benefit entitlement of those receiving health and /or social care in different settings, obstructed and diverted the process of community care policy implementation from the stated objectives. They created perverse incentives in favour of particular service models that have not worked in either users' nor tax-payers' interests (Audit Commission 1997, 1999, 2000). Case law developed supposedly clarifying the respective responsibilities of health and local authorities left ambivalent by statute. What appeared to be cost- shunting exercises between statutory authorities and respective budget managers, facilitated by lack of clarity in the wording or intention of government policy guidance, had an impact on peoples' lives at the point of service delivery. They created dilemmas for practitioners attempting to reconcile the interests of their managers and public paymasters with those of their citizen- clients.

The cumulative consequences of community care policies resulted in a move from 'universal' access to N.H.S. provision to discretionary access to residual local authority services. Rummery and Glendinning's (1999) research, into the impact of this trend on the lives of older and disabled people, found that traditional professional gate keeping activities (like the medic's decision whether to admit a particular patient to hospital) have been augmented by a range of new obstacles. They defined 'managerial gate keeping' as the structures and processes agreed by managers, which direct the functioning of care management teams, including eligibility criteria. They define 'bureaucratic gate keeping' procedures, as those used by receptionists and duty social workers in their first engagement with potential service users. Rummery and Glendinning found, for example, that social workers raised the prospect of charges to deter potential applicants for services before commencing a full assessment of need.

The Coughlan judgement (R v N and E Devon Health Authority ex parte Coughlan 1999) and consequent Department of Health circulars confirmed that the boundary between health and social care shifts. The boundary is moved by political and judicial decision makers, rather than professional expertise. This ruling threatened to further compromise the situation of individuals with high levels of care needs requesting re-assessment to access direct payments. Those re-

designated as 'continuing care' patients within a community context became the sole funding responsibility of health purchasers. The direct payment option could be withheld if social services were relieved of funding responsibilities for the individual. The 'right to buy' in community care appeared to be inextricably linked with the 'responsibility to pay'.

In New Labour's first policy documents on the extension of direct payments, the distinction between health and social care was drawn again. Cash payments were not to be made in lieu of health services in the community (Dept of Health, 2000a) despite evidence that direct payment users prefer to have their health and social care services delivered in an integrated way, often by the same personal assistant (Glendinning and colleagues 2000a). The practitioner responsible for the assessing the individual was therefore required to separate health and social care needs in the care plan. Only services that addressed the latter could be converted into a direct payment.

The Health and Social Care Act (2001) threatened the imposition of Care Trusts on local authorities, to be responsible for both health and social care in the area. At the local political and managerial level, the Local Government Association and the Association of Directors of Social Services expressed concern about the implications of the new legislation (Rickford 2001). The 1999 Health Act, had already permitted closer local partnerships between health and social services. Dean (2001) argued that the granting of commissioning responsibilities to new 'health' bodies (the Care Trusts) threatened to fragment community services. Rather than facilitating 'joined-up' services, the potential separation of responsibilities for 'community care' provision from that of supported housing, for example, appeared to conflict with other objectives of central government's policy (Dept. of Health 1998c). The New Labour policy of promoting Care Trusts appeared to subject the needs of the people who depend on community care services to an individual or 'medical model'. Some feared this threatened the hard won achievements of the disabled peoples' rights movements in gaining widespread acceptance of a 'social model' of disability. Henwood (2001, 58) reported the concerns of users that social care is to be 'taken over' by the N.H.S. *'which is seen as 10-15 years behind in its attitudes to disability'*. The social model is an approach to needs that recognises the disabling nature of environmental and social factors and the way in which they exacerbate the effects of individual impairment, illness and age⁸.

3.1.4. Individual and group involvement, co-operation and conflict in implementation

The extension of direct payments, both geographically and in terms of numbers and user groups, required the confidence and co-operation of a multiplicity of stakeholders, with potentially divergent interests, what Hjerm and Porter (1997) called 'implementation structures.' These

⁸ That is notwithstanding the criticism from Tom Shakespeare (1994) that the social model neglects important aspects of the experience of being disabled.

ranged from the Department of Health to local politicians, from managers to practitioners, from council solicitors to accountants and auditors, from large and small voluntary organisations to individuals and carers. It potentially involved a shift in the balance of power from both local to central government and from those who provide the services to those who use them.

Despite the slow start (Dept of Health 1998a, Wellard 1999), research indicated that all but one of the 171 local authorities in England and Wales would introduce, direct payments before being obliged to by a Labour government (Jones 2000). However actual take up continued to vary widely across the country, within regions, between client and ethnic groups and individual caseloads. Councils were encouraged to 'involve' service users in the planning, development and management of local schemes (Dept of Health 2000a).

Lack of clarity in guidance from central government and apparent inconsistencies within the overall policy framework can affect the development of direct payments. In the implementation context they leave 'space' for a number of different interests and interest groups to interact, negotiate and promote alternative interpretations of contested concepts like participation (Clarke 2000), care (Morris 1997), inclusion (Lister 1998) and community (Levitas 2000). Jordan (1999) argued that the notions of common interests and shared values are contingent upon the nature of the collectivity under consideration, from a single household, through a neighbourhood to a nation state and the global economy. Levitas (2000) observed that communities of interest cut across geographical boundaries and local economies, as well as social classes. The actions, experiences and attitudes of 'street level bureaucrats' and the influence and interaction of interest groups are two of the ways in which central government's policy intentions are mediated during the implementation process.

3.1.5. Interest groups and statutory coherence

The implementation research literature was reviewed by Sabatier (1986). He concluded that the following factors influence the success of policy implementation, each of which may be relevant to community care policy implementation. They are causal adequacy (that is whether the theory on which the initiative is based predicts the conditions for success); political and interest group support; legal powers and constraints; financial resources; official / bureaucratic commitment and the social and economic environment. The issue of 'causal adequacy' was discussed earlier with reference to the validity and relevance of the assumptions of neo-classical economic theory to community care markets and direct payments.

The growing importance of consultation in policy making during the Thatcher administration was discussed by Maloney and colleagues (1994). They argued that some interest groups come to exercise influence, through sharing political and technical knowledge with civil servants, at

the cost of compromising their more radical objectives. Fragmentation within 'the state' means parts of the civil service bureaucracy define their goals in terms of satisfying 'group clienteles'. The relevant departments have expectations imposed on them that limit their discretion because of the '*clientelistic tendencies in the fragmented state*' (Maloney and colleagues 1994, 23). Maloney's account may shed light on the debate described earlier. This questions whether the initial conferring of *powers*, rather than *duties*, to local authorities to make direct payments for community care represented a victory or a compromise in the struggle of disabled people for the right to self determination and a decent lifestyle. The idea of the fragmented state helps explain how central government can produce policy initiatives that appear to impose contradictory expectations on lower level authorities responsible for implementation.

A 'statutory coherence' hypothesis was proposed by Meier and Mc Farlane (1996) from their policy implementation case study. Coherent statutes, with precise goals, supported by an adequate causal theory, with clear administrative responsibilities and implementation rules, assigned to committed agencies, are most likely to have their intended impact. They concluded that the success of policy implementation is to a large extent a function of how it is 'crafted', including the language used in writing legislation. The effect of 'statutory coherence' persisted through the 'third stage' of implementation, to the actual policy outcomes. The Blair government promised clarity in its objectives and expectations of local authorities in its 'modernisation' proposals as a way of ensuring their success:

'Up to now, neither users, carers, the public, nor social services staff and managers have had a clear idea of which services are or should be provided....this lack of clarity of objectives means on the one hand that social services can not be easily held to account and on the other hand that they can be blamed for anything that goes wrong..' (Dept. of Health, 1998a, page 2)

New Labour also promised 'joined up' thinking and action in the drafting (or 'crafting') of policy. The impact of community care policy and new public management on social work and the potential relevance of the research to the case study is discussed next.

3.2 Community Care, Social Work and Direct Payments

'It is a very considerable understatement to talk of the inherent tensions between the various social work roles- as agents of the state, counsellors and advocates..' (Brandon and Brandon 2002, 49)

Issues raised by radical changes in organisational arrangements, social work practice and the relationships between welfare agencies and users of services may influence the progress of direct payments. The changes, began in the implementation of the community care policy of the 1990s, and continued with the Blair government's modernisation programme for social services (Dept. of Health 1998a).

'Foremost amongst these changes has been the division between providing and purchasing roles, the consequent growth of independent sector providers, the growing emphasis upon 'partnership', the changing role of social work as a profession, the shifting balance between central and local government, and the emergence of users and carers from the role of passive recipients.' (Hudson 2000,7- 8)

The development of the role of service user as purchaser through direct payments seemed, from a consumerist perspective, a natural progression in the implementation of community care policy and the development of care markets. However the transformation of social workers into care managers followed a less direct route. Social work was separated from the administration of financial assistance for the first time in 1948. The National Assistance Act, in repealing the Poor Law, created a national system for the payment of cash benefits to the 'poor' and left the provision of welfare services to local authorities. Although most people using the personal social services have received social security benefits, this distinction was perceived as progressive in detaching social workers' clients from the stigma of the Poor Law. It has been used to explain some of the reported reluctance of social workers to embrace their potential role in the implementation of direct payments. Glasby and Littlechild (2002, 8) suggest that *'the involvement of social workers in making cash payments to disabled people represents a fundamental shift in the nature of the profession, turning the clock back fifty years.'* However in their role in the implementation of charging policies, discussed earlier, social workers have had an impact on the disposable resources left available to some social care users since 1948.

The research discussed earlier suggests that the evolution of the 'mixed economy' from the 1990s neither enabled nor motivated social workers to develop their market power, to promote competition and 'efficiency', as representatives of both the end users and public funders of services. One study carried out during the early implementation of community care found that practitioners used traditional casework methods to complement their new responsibilities. Despite frustrations with increased demands for 'paper work', social workers approached their care management duties creatively to promote user choice and advocacy (Hardiker and Barker 1999). Later studies, however, suggested that the growth of care management undermined the social worker's traditional role. The experience of social workers in primary health care teams, following the implementation of 'community care', was explored by Hudson and colleagues (1997). They found that despite expectations of a clash between the medical/ individual and social model, attachment to a general practice allowed practitioners to return to social work approaches, based on relationships with individuals and communities, instead of the quick turnover, 'client processing' requirements of care management. Four issues that have impacted on the nature of social work practice were identified by Postle's (2001) study. They were: the introduction of a 'market' in social care; constant policy change leading to unintended consequences; restricted resources with associated rationing procedures and the growth of

managerialism reducing the role of professional supervision. Practitioners struggled to retain elements of what they understood to be 'social work' in their care management practice. Increased focus on turnover and 'gate keeping' resources was at the cost of the traditional 'use of self' in relationship based work, with a 'tick box' approach replacing holistic assessment.

The introduction of a 'competency based' approach, in social work and training, was discussed by Dominelli (1996, 172). This occurred under Conservative governments and, did not happen in response to user need or professional aspirations, but rather to an '*ephemeral and unaccountable market*'. The result was a shift in power from social workers to managers and budget holders who have no contact with clients and the reality of their lives. Practitioners and service users were excluded from the process of defining the roles and requirements of social workers. Holistic approaches to understanding the needs of individuals in their social and political context, and relationships between individual workers, clients and their communities were undervalued. The government was able to use a technicist, 'competency based' focus to establish ; '*forms of intervention which further disempower users whilst clothing their activities in the rhetoric of citizenship and empowerment.*' (Dominelli 1996, 172).

For Newman (2001), the dominant line of tension in the Conservative government's attempts to control the behaviour of public servants was between managerial forms of power and self-regulation. The tension has continued as New Labour has attempted to extend control over both the *outputs* and the *processes* of professional work in the public sector. Newman used the failure of Blair's government to engage the teaching profession with its modernisation plans, as one example of how New Labour's programme both sought collaboration and threatened coercion.

From another perspective, McKevitt and Lawton (1996) interviewed middle managers from various public services. They found that performance targets imposed centrally did not lead to users' needs being met but to officer disenchantment, with ambiguous operational objectives creating opportunities for internal politics and goal displacement. Performance measurement systems designed by politicians and senior managers, without regard to the realities of implementation or the voices of citizens, were being used routinely to demonstrate compliance with external stakeholders. McKevitt and Lawton suggested that in the conflict between professional and managerial goals in public services, the interests of users may be protected and promoted through the alliances of weaker stakeholders.

The case that New Labour's 'modernisation' programme for public services carried forward the process of change initiated by Conservative governments was supported by Hunter (2001, 57):

'...the government has maintained a greater degree of continuity that its rhetoric would suggest. It remains wedded to 'new public management' precepts when it comes to its management style.'

New Labour emphasised managerialist solutions to social problems, that is 'joined up government' and 'what works' pragmatism. Lister (2001) argued that this neglected political responses to structural divisions when they were also needed. The Blair government also distanced itself from ideological commitments to market devices through the narratives of performance management, partnership and participation.

The values and aims of practitioners and those of the new public management conflicted. Newman (2001) suggested that the 'identity- based trust' between staff and their employers traditionally based on shared public service values was eroded by the latter. Flynn (1999) argued that managerialism replaced the teamwork, leadership and professional support and supervision that characterised traditional social work practice. Managers' concern with organisational objectives, including budget control and quantifiable performance indicators, contrasted with the individual client orientation of practitioners. Procedurally led, rule bound practice marginalised professional values and undermined efforts to promote user empowerment. New Labour's reliance on the tools of performance management in its programme for 'modernising' social services (Dept of Health 1998a) threatened to exacerbate, rather than resolve, that conflict between managerial and professional values.

In an analysis of the relationship between social work and 'third way' social policies, Jordan (2000) discussed the nature of the changing demands on social workers during the Thatcher/ Major years and their legacy under the Blair administration. 'Tough love' encapsulated New Labour's expectations. Social work became increasingly legalistic, procedural and at arms length, concerned with rationing resources and controlling risk. Jordan (2000, 9) argued that in approaching 'third way' initiatives, social workers faced a 'classical' dilemma that has always 'haunted' the profession:

'Should they seek to make third way policies more 'user friendly' for citizens (reformism) or should they try to mobilise resistance to its oppressive features?...In practice social work nearly always combines these two elements and is therefore an ambiguous, ambivalent activity.'

Social workers had key roles in the implementation of direct payments, informing clients of their 'rights', applying rationing criteria to their 'needs' and assessing their 'suitability' to manage their own care arrangements (Bewley 2000, Evans and Carmichael 2002, S.S.I. 2000).

Two broad approaches to the exercise power by practitioners, inherent in their roles and relationships with disabled people, were distinguished by Barron (2001). 'Professional support' focussed on enabling service users to assert their rights and achieve self- determination. In contrast 'professional control' emphasised gate-keeping resources and restricting life style choices. Examples of the first approach were practitioners who disregarded budget constraints to enable clients to achieve the quality of life they desired and who encouraged them to

challenge adverse organisational decisions. Examples of the second were a practitioner who cut the number of hours of support a user received because they were being used to facilitate social outings, and another who prevented a user seeking a partner through a 'personal' column.

The tensions that characterised the changes in the duties of social workers, with the development of care management within community care policy, were brought into sharp focus by direct payments. The role of advocate of individual autonomy was combined with the role of gatekeeper of needed care and support services. In the 'third way', it is where individual rights must be reconciled with social responsibilities or where 'tough love' is expressed through the assessment of who is deemed trustworthy to manage their own care. The social worker's efforts to reconcile these conflicting pressures in the context of a 'discourse of failure' perpetuated in New Labour's plan for modernising social services (Dept. of Health 1998a) could not be simply understood as self interest or self-preservation.

'..as the 'community' became the solution to every problem in the 1980s and 1990s, those burdened with the responsibility of turning political rhetoric into the reality of services on the ground for those in need- without additional resources- also carried the burden of the inevitable ensuing disappointments.' (Langan 2000, 156)

The motives of another group of practitioners were explored by Taylor- Gooby and colleagues (2000). Dentists left the NHS, in response to government attempts to alter the focus of their interventions with patients. The study concluded that efforts to motivate professionals to pursue government policy objectives must take into account social factors, including professional cultures which influence how practitioners perceive their own and their clients' interests.

'Third way' social policies have features in common with the 'new orthodoxy' of evidence based practice in social work according to Jordan (2000). Both represent a 'top down' social engineering approach to social intervention based on an instrumental conception of technical rationality and utilitarian motivation. Jordan identified a 'counter- movement' of diverse elements within the social work practice. The *interactionist* tradition understands how meaning, identity and order are constructed through face-to-face communication and achieved co-operatively rather than being part of a structure through which individuals follow rules and procedures. The *emancipatory* agenda acknowledges issues of power because to ignore them would be to covertly side against the oppressed. 'Anti-oppressive practice' supports individuals in challenging the sources and consequences of discrimination. The tradition of *community work and community development*⁹ pursues the empowerment of the disadvantaged through collective action and demands that services are accountable to local people. The newer notion of the

⁹ Ascendant in the seventies and now mainly in the work of Bob Holman (1998)

'*reflexive practitioner*'¹⁰ revalues judgement, experience and learning by doing, rather than just the rigorous application of research-based knowledge and competence based training.

Local authorities were among the main centres of resistance to '*Thatcherite ideas and institutions*' in the 1990s and so were attacked by ministers and villified by the '*Tory press*' (Jordan 2000, 74). The Blair government's focus on performance management indicated a concern that its own policy reforms should not be subverted by those responsible for their implementation. The Audit Commission and Social Services Inspectorate's (2001) overview revealed that one third of the authorities inspected through the 'Joint Review' process (which tests councils' performance against centrally set criteria) had uncertain or poor prospects with only eight per cent achieving 'excellence'. Jordan (2000) argued that the *modernising* programme was intended to control the behaviour of both social service staff and service users (Dept of Health 1998a) giving resonance to Le Grand's (1997) thesis about the growing distrust of the motives of public servants. Therefore despite the official aims of improving training and raising standards, under New Labour social work was being deskilled, made more mechanical and administrative, with reduced scope for judgement and interpretation. Nevertheless: '*Those who give and receive social services obstinately refuse to interpret their work or describe their tasks in the way that law, policy and guidance require.*' (Jordan 2000, 38)

The 'forces of conservatism' amongst public service workers (Blair 1999) may prove to have been the force of resistance that Blair feared (Taylor- Gooby 2000).

The change in focus in social work from professional accountability (to the service user) to public accountability (to the employer and wider public) was revealed in the accounts of social workers reported by Banks (2002). They described a growing concern with assessment of risk and associated defensive practices in supervision and recording, together with bureaucratic, procedurally led practice. Professionalism was criticised in the 1970s and 80s by politicians and academics as concerned with self interested, defensive practices. Aldridge (1996,180) explained how professionalism was also rejected by the radical social work movement:

'For them, to be a professional, as opposed to a trade unionist, was simultaneously to perpetuate mystificatory and individualistic therapeutic methods of work and the controlling functions of state social work.'

Social work has not enjoyed the recognition or professional status of other qualification based occupations. Aldridge (1996) attributed this to its dominance by women, the low status of its client group and the residualist stigma from the Poor Law origins of the personal social services. She observed that social work was similar to other 'professional' occupations, like general practitioner or minister of religion, in requiring a range of technical, bureaucratic and inter personal knowledge and skill rather than a distinct cognitive base. The difference was that the

¹⁰ see Martyn (2000)

social work portfolio was determined by the government of the day, in an environment where members of the profession had little influence over policy making. Aldridge suggested that social work struggled with and survived Thatcherism but with the focus of practice significantly altered from direct work with clients to the organisation of care packages. Nevertheless social workers had considerable 'operating space', even within state bureaucracies, because of the privacy of the one to one encounter and their steady flow of clients. Attempts to shift the framework of analysis from a social to an individual model threatened the long-standing efforts of social workers to enable their clients to address the social injustices that they experience as personal problems. Roberts (2001, 23) criticised Blair's government's efforts to recruit to the profession with the campaign slogan that social work is '*all about people*' rather than politics and power. New Labour created the General Social Care Council, to regulate training, set standards and register practitioners without granting social workers the professional status, control over entry and the self-regulatory powers of the professional associations of health practitioners. It has therefore been described as '*yet another example of centralised control and monitoring*' (Hudson 2000, 233)

The implications of the development of community care policy and its impact on social work/ 'care management' practice and the relevance of contested concepts discussed in the literature is explored in this study through the example of direct payments.

3.3 Conclusions from the Literature and Research Questions

The policy studies literature and studies of community care implementation support the thesis that policy action cannot be understood from only a top down or a bottom up perspective. My research explored these theoretical issues and their relevance to the Blair government's approach to policy implementation through the example of direct payments.

The literature suggests that policy 'made' by the party in power in pursuit of its objectives is formulated in negotiation with interests and interest groups. The New Labour government was determined to '*modernise*' public services. It intended to achieve its objectives through a clear leadership, characterised by 'joined-up' thinking, pragmatism and user participation in policy implementation and centralised performance management. My first question therefore asked:

Was central government's approach to policy making clear and coherent within its modernisation programme and what were the implications for implementation?

The literature highlighted the complexity of policy action when implementation responsibilities are delegated by one tier of government to another (Hill 1981, Hjern 1982), so I asked :

What were the implications of central government's approach to achieving its policy objectives by delegating responsibility for implementation to local authorities?

The work of Pearson (2000) and Priestley (1999) suggested that local authorities have not been neutral actors in the policy implementation process. I therefore asked next:

How did political ideology, interests and alliances shape policy formulation and implementation at the local authority level and how were tensions between policy objectives reconciled?

Policy continues to develop through the actions and interactions of actors in the implementation process, including front line public servants and the citizens (Lindblom 1959, Scwandt 1997). How people carry out their implementation responsibilities is influenced by how they understand the policy's objectives and its theoretical and ideological underpinnings, as well as their personal interests (Taylor-Gooby 2000). They may deliberately or inadvertently advance or subvert progress towards the achievement of central government objectives through their contributions to the policy- action process. Research has highlighted the significance of 'street level' policy making by practitioners (Lipsky 1980, Wells 1997). The role of public servants in assisting or obstructing the policy implementation cause political concern (Blair 1999, 2001b). My next question was:

How did practitioners understand central government policy objectives and what were the influences on their actions in policy implementation?

The Blair government expected that service users and citizens should be 'involved' in the policy implementation process (Dept of Health 1998, 2000). I therefore asked:

What part did service users/ citizens play in the policy implementation process and how did they understand their participation?

The 'third way' emphasised on the role of the 'reflexive citizen' taking individual responsibility for decisions previously left to politicians and professionals (Giddens 1998, 2000). New Labour in government stressed the importance of user choice and control as both a means to and outcome of effective policy implementation (Dept. of Health 1998). Because the guidance on direct payments also made assumptions about the motivation of service users (Dept of Health 2000, 2002), I asked:

Why do some community care service users want to manage their care arrangements through direct payments and how does the implementation process assist or obstruct them in realising their personal objectives?

Finally, because the national figures (Dept. of Health returns 1998 to 2002) showed the modest extent and expansion of the use of direct payments by community care service users, I asked :

How does a study of the policy- action process help explain the lack of 'success' of this initiative in engaging most disabled people in the management of their own care arrangements through direct payments?

CHAPTER FOUR

Methodology

'The case study approach is appropriate when the researcher wants to : define topics broadly and not narrowly; cover contextual conditions and not just the phenomenon of study; and rely on multiple not singular sources of evidence.' Yin (1993,11)

4.0 Introduction

The case study explored the policy-action process through the example of direct payments. This chapter introduces the research approach in general terms and then gives a more detailed account of the methods used. The overall approach was informed by the work of Sabatier (1986) and Pawson and Tilley (1997). This research illustrated that policy making and implementation do not proceed in a single direction just as Lindblom and Woodhouse (1993, 11) asserted. The findings are consistent with a generative rather than a successionist model of causation in the policy field as promoted by Pawson and Tilley. The metaphor of the policy-action 'chain' is therefore used as an alternative to linear or hierarchical symbolism.

A synthesis of the 'best' features of both 'top down' and 'bottom up' approaches to policy implementation research was recommended by Sabatier (1986). The synthesis approach focuses on the 1) effects of socio-economic (and other) changes external to the policy network/sub-system on actors' resources and strategies; 2) attempts by actors to manipulate the legal attributes of governmental programmes to achieve their objectives over time; and 3) actors' efforts to improve their understanding of the magnitude and factors affecting the problem, as well as the impacts of various policy instruments, as they learn from experience. Sabatier's synthesis began with the 'bottom uppers' concern with understanding the perspectives and strategies of the public and private actors involved with a policy problem. This was combined with the 'top downers' interest in the ways in which socio-economic conditions and legal instruments constrain behaviour. In terms of the study of policy change the case study fieldwork took place over a relatively short period (two years). Sabatier (1986, 39) suggests '*a decade or more*' is needed to encompass opportunities for policy- oriented learning by the actors involved. This issue was addressed in the case study by a consideration of the development of one policy initiative (direct payments) within the context of the experience of and opportunities for policy-oriented learning by, the actors in the implementation of the wider social policy programme (community care) over a longer period.

In designing and implementing this case study I drew on the advice of Pawson and Tilley (1997, 71) that realistic investigation needs to be theory rather method driven and therefore that the 'programme' studied should not be treated as a 'black box'. In evaluation research this means not simply identifying 'what works', but attempting to uncover how a policy initiative works. Explanation should take the form of positing some underlying 'mechanism', what it is

about an initiative that makes it work. This involves propositions about the interplay between structure and agency. Explanation should also include an investigation of how the working of such mechanisms are contingent and conditional and only fired in particular local, historical or institutional contexts.

The case study was not an evaluation of the effectiveness of a particular policy initiative in the terms of Pawson and Tilley's description of a project that asked how, in what circumstances, were specific policy outcomes achieved. It explored the policy making- implementation process in action, through the Blair government's approach to achieving policy effectiveness (Dept of Health 1998a). It therefore considered how, to what extent and in what circumstances, were the ends and means desired by policy makers clear to policy actors and whether the 'means' and intermediate objectives of policy implementation were used to indicate and in so doing replaced the ultimate 'goals'. In the case of direct payments the inspiration for policy change was an earlier evaluation (Zarb and Nadash 1994) that identified positive outcomes of increased user satisfaction and cost effectiveness. The ultimate objectives identified by the Blair government (Dept of Health 1998a and 2000a) were independence, choice and control for community care service users and cost effective use of resources in achieving user priorities. It was therefore an investigation or 'evaluation' of the effectiveness policy-action process through a case study.

4.1 The case study approach

The research was concerned with the process of implementing a particular initiative within a programme of policy change. The extension of direct payments was the key unit of analysis embedded within the wider unit of the Labour government's social policy programme. It drew on an in depth study of one social services department and the actors, groups and agencies it engaged with in implementation. The focus on one authority provided the opportunity to explore in depth the complex interactions and interrelationships between actors, organisations and events in the policy- action process and how they effect the progress and outcomes of implementation. The objective was to include all relevant stakeholders, as Sanderson (2002, 449) advocated, recognising, their interest in the policy and to understand their perspectives, theories of change, arguments and actions in relation to their organisational, institutional and social context.

The issue of generalisation from a case study was addressed by Bryman (1988). He recommended using a case that is 'typical' of a certain cluster of characteristics. Direct payments were chosen as the case because it had the typical characteristics of both a 'third way' initiative within Labour's 'modernisation' of social services and a community care policy. It was an example of implementation that involved the use of discretion in decision- making at the local political level (enacted initially by 'permissive legislation') and the exercise of judgement

by practitioners. It had characteristics typical of public policies discussed in the literature reviewed earlier. Direct payments were an initiative that could not be imposed on individual citizens, but required their 'active' participation consistent with the 'third way' ideal.

The issue of the wider relevance of a case study is one of generalisability to theoretical propositions rather than to populations or universes. Therefore what is crucial is that the experiences of the actors involved are typical of the broad class of phenomena, the complexity of social policy implementation. Bryman (1988) suggested that concern about generalisability as a 'problem' of case study research is based on a misconception, arising from a tendency to approach a case study *'as if it were a sample of one drawn from a universes of such cases'* (90). Instead within a case study a range of different people and examples are studied, so that the approach is not entirely different from the 'survey sample', particularly as samples are often drawn from a geographical locality. Within this case study, I interviewed people engaged in a variety of activities, many who had experience from a variety of roles, locations, services and sectors in the receipt or delivery of community care. Informants reflected on their experiences through their roles as both 'expert witnesses' and 'native informants' (Strong and Robinson 1992). Pawson and Tilley (1997) refine the issue of 'generalisability' further, recommending that within individual 'cases' attention is given to testing theories about way that 'mechanisms' and 'contexts' interact to produce regularities and outcomes. In their examples from crime prevention studies, they specify the particular circumstances in which interventions work by introducing the appropriate ideas and opportunities (mechanisms) to the appropriate social and cultural conditions (contexts). The aim is therefore specification of what happens to whom in a set of given circumstances rather than unconditional or unqualified generalisation. However Pawson and Tilley (1997, 150) caution that the social world is in continuous flux and even where it may be possible to specify local contextual conditions for mechanisms to be triggered, ensuring that those circumstances are stable will often be impossible.

Because the policy of extending direct payments for community care is the 'unit of analysis', the experience of implementation in another area were drawn on to place my observations of one social services department in a comparative perspective. Comparison showed how the interaction of mechanisms and alternative contexts might produce different or similar results. Bryman (1988, 88) described another field study where there was concern that observations made in a single location were in some way 'untypical' and therefore limited in their contribution to wider theoretical developments. He referred to Skolnicks's study of the police through participation observation of officers in one US city ('Westville') was supplemented with a shorter study of another police department ('Eastville'), enabling him to place his observations of Westville in perspective and to develop a number of contrasts between the two forces. Bryman (1988) discussed how comparison with experiences in another area allowed

some exploration of the wider relevance of the specific instances explored in depth in one historical and geographical context.

4.1.1. Participant observation, access and the role of the research student

Participant observation has been described by Lofland (1984, 12) as a process through which an investigator establishes a many-sided and relatively long term relationship with a human association in its natural setting. Pawson and Tilley (1997, 64) discussed the stratified nature of social reality and argued that all human action is embedded within a wider range of social processes and in built assumptions about a wider set of rules and social institutions. Participant observation offered an opportunity to understand processes operating at the institutional and individual levels of analysis. Burgess (1991, 79) suggested that participant observation provides an opportunity to collect rich detailed data, to obtain accounts of situations in the language of the subjects, to gain access to the concepts used in everyday life and to collect the different versions of events that are available.

My fieldwork was carried out over two years and involved spending an average of two days a week observing and talking to actors involved in community care and particularly in the planning and introduction of direct payments. It therefore continued for a fairly long time period and in a reasonably flexible manner as the literature advocated. This meant that the 'regularities and rituals of everyday life' in a social services department could surface in a natural fashion (Van Maanen, Dabbs and Faulkner 1982). The multiple methods described were employed mainly in my role as 'participant- observer' (Burgess 1991, Johnson 1975). The following account of my role as a participant observer illustrates the context in which I used the particular research methods.

To explore the various 'links' or points of interaction at which policy action occurs, I needed access to the range of actors involved in the process over a prolonged period, equivalent to the time scale prescribed by central government policy directives. I sought to understand the implementation context, in particular the political and historical development of community care and to have access to the relevant national and local policy documents. I therefore carried out my fieldwork as a research student located with one social services department serving one community. As well as facilitating access to key actors within the authority, I had the opportunity to engage with representatives of other organisations in the public and voluntary sector and with individuals who used services. My role included assistance with the introduction of direct payments. I provided information based on the development of similar schemes in other areas and sought advice and guidance both from the National Centre for Independent Living,¹¹ and with responsible civil servants.

¹¹ funded by the Department of Health to help local authorities with implementation issues

I observed meetings, interviewed individuals and talked to groups about their understanding and experiences. I also observed and participated in informal conversations relevant to the research questions and tested out my understanding of my observations as they were occurring.

Irrespective of ethical issues discussed below, for practical reasons my role as researcher could not be covert. The actors understood that I was 'placed' in the authority to assist with the introduction of direct payments through providing information. They were however aware that my own research interests were in the policy development and implementation processes, phenomena that interested and affected them.

The literature on participant observation (Bryman 1988, Burgess 1991, Johnson 1975) suggested that the point of access to a setting can influence the subjects' perception and acceptance of the researcher. Access to the local authority was negotiated between senior managers in the social services department and the University of Durham. In exchange for their participation in my research, I offered staff lower down the social services hierarchy as well as service users a channel of communication. Staff were able to ask me for information, to which they did not have easy access, about planning and decision-making processes that impacted on their work. They could also express their views and concerns to senior management, without identifying themselves individually. Service users, carers and voluntary sector workers were also given a 'voice' in decision-making forums where their insights would not otherwise have been represented, but I clarified that I could not ensure that it would be listened to.

I found that my presence seemed to be accepted by workers and service users across the authority, unlike the experience of Johnson (1975). His role as a Ph.D. student in a U.S. social services agency was regarded initially with suspicion by staff, who feared he was an 'undercover' investigator following the arrest of a colleague. Public service organisations routinely provide training placements for a variety of 'students'. My role as a participant and/or an observer across a range of activities and situations was not regarded as exceptional, nor were my requests to read policy documents, procedures and reports considered problematic. Furthermore my independence from the council and the other local agencies had advantages for the collection of the data I sought on personal experience and understanding of policy in action. My role offered an opportunity for actors to express their views and reflect on their experiences with someone perceived as having some insight and concern, without a vested interest. Robson (1999,160) asserted that the case study approach relies on the effectiveness of the 'human instrument' rather than the data collection techniques *per se* and that familiarity with the phenomena and setting under study are an advantage for the researcher. He acknowledged that such familiarity is not advocated universally. I would argue that familiarity with the organisational and policy context and the language and meanings of many of the actors, from personal experience of the policy action process within social services departments, enhanced

the effectiveness of the human instrument in this study. With regard to my personal characteristics, I match the stereotype of the 'typical social worker' identified by Seeborn (1968), 'the middle aged, middle class, white woman'. In the local authority I studied seventy five percent of the care management staff and more than half the social services team and senior managers were white women. Ninety percent of the direct care staff were white women, there were no male home care workers for example. I also have a northern accent. Notwithstanding my independent status, I am the sort of person people are used to seeing around and talking to.

4.1.2. Ethical issues

I followed the BASW code of ethics and BSA guidelines in designing and conducting this research and paid attention to the 'ten questionable practices' in social research identified by Robson (1999, 33). I found no reason to employ any of these practices or potential benefits to be derived from their use. I was aware that working to ethical codes can provide a false sense of security and dull the researcher's sensibilities to the issues of research in contexts where power is unevenly distributed. I did not need to involve people without their consent, or to deceive them about the nature of my research. Instead it was essential to my approach that they understood that I was trying to explain the policy implementation process and sought their experiences and theories of policy change. However I was conscious that some of the experiences described by users, carers and practitioners could be painful and took this into consideration. I recognised and respected the contributions of all the informants and tried to give them equal weight in my reporting and analysis, irrespective of the particular nature of their careers and relationships with welfare and community- care services. May (1997, 61) asserts that knowing about the ethical issues is not a sufficient basis on which to conduct research. Consistent with his advice, ethical considerations formed part of the research process itself and decisions in the design of the case study (described below) were made on that basis.

4.2 Stages in the Design of the Case Study

Robson (1999, 150) advised that case study design is a continuing process through the course of the study. A major strength of the approach was that it enabled me to respond flexibly to the complexity of the policy-action process, unraveling the policy-action chain as links, breaks and tensions became noticeable. The main features of a case study and their presumed relationships are covered by the conceptual framework, from which according to Robson (1999) research questions are formulated.

4.2.1 The conceptual framework

My conceptual framework drew on the general policy studies literature and more focused work on New Labour's approach to policy implementation, research into the experience and effectiveness of the implementation of community care policy and the history and development

of the particular initiative. I identified features and the relationships that were likely to be important, bearing in mind that complexity theory (Pawson and Tilley 1997, Sanderson 2002) predicts that in a particular set of circumstances or initial conditions the interaction of 'variables' can have consequences disproportionate to their apparent significance individually.

The features identified were : the **historical context**, the background to the development and implementation of the initiative nationally and locally and the legacy of the Conservative governments' reforms; the **policy context**: community care policy and the New Labour 'modernisation' programme for public services; the **political context** : New Labour's 'third way' and the conflict with 'Old Labour interests', the local response and the power struggles between decision makers; and the **actions and motivation of the various 'stakeholders'** in the initiative, including their experiences and expectations of policy change, their understanding of the particular policy initiative and their values and objectives.

'The realistic explanation of programmes involves an understanding of their mechanisms, contexts and outcomes, and so requires asking questions about the reasoning and resources of those involved in the initiative, the social and cultural conditions necessary to sustain change and the extent to which one behavioural regularity is exchanged for another.' (Pawson and Tilley 1997, 154)

4.2.2. The research questions

The research questions are followed by a description in broad terms of how they were addressed. A more detailed account of the methods used is then given.

1. *Was the central government's approach to policy making clear and coherent within its modernisation programme and what were the implications for implementation?*
2. *What were the implications of central government's approach to achieving its policy objectives by delegating responsibility for implementation to local authorities?*

The methods used to address these question were:

Documentary analysis of central government guidance and policy directives.

Participant observation at conferences and seminars held to discuss and promote the policy programme or the particular initiative and **conversations** with other participants.

Semi structured interviews and conversations with actors at the national level contributing to the development and communication of policy during the study period :the responsible minister, department of health civil servants, a co-director and the information officer of the National Centre for Independent Living, (a voluntary organisation developed, run by and employing disabled people) and **actors at the local level** responsible for interpreting and implementing the initiative :senior councillors, senior officers, planning , contracts and management information staff , social work managers and practitioners.

3. How did political ideology, interests and alliances shape policy formulation and implementation at the local authority level and how were tensions between policy objectives reconciled?

The methods used to address this question were:

Documentary analysis of local policies and records of the outcomes of decision making processes (committee reports); minutes of meetings and written accounts of consultation processes and research reports.

Semi structured interviews with individual actors involved in the local policy making and planning processes : leading councillors, senior officers and policy and planning staff, social work managers and practitioners.

Group discussion with the then controlling Labour group of councillors.

Participant observation of : meetings of senior managers at which recommendations to political decision makers were discussed and agreed; formal and informal meetings between those involved in planning the implementation of direct payments

4. How did practitioners understand central government policy objectives and what were the influences on their actions in policy implementation?

5 What part did service users/ citizens play in the policy implementation process and how did they understand their participation?

The methods used to address these questions were:

Participant observation of and **informal discussions** with the actors involved in :the planning groups responsible for planning the implementation of the initiative and consultation events organised by the social services department.

A survey of practitioners (care managers and care providers) between April and June 2000 before the planning stage of the implementation process ;

Semi structured interviews with :key practitioners involved in the implementation of direct payments; the first service users and carers to express an interest in the initiative; with citizens involved in the planning and implementation processes and with staff employed by local voluntary organisations with responsibilities for helping to facilitate citizen participation.

Group interviews with : community care service users attending a day centre ;practitioners from other agencies (housing and health) who have day to day contact with social care service users and carers.

6. Why do some community care service users want to manage their care arrangements through direct payments and how does the implementation process assist or obstruct them in realising their personal objectives?

7. How does a study of the policy- action process help explain the lack of 'success' of this initiative in engaging most disabled people in the management of their own care arrangements through direct payments?

The methods used to address these questions were:

Interviews with :users and carers who expressed an interest in direct payments; care management practitioners, management and advocacy staff in voluntary sector organisations.

Group discussions: with sheltered housing wardens and day service users

4.2.3. The sampling strategy

Policy programmes, according to Pawson and Tilley (1997, 160), are complex social organisations. They argue that understanding them demands that investigators are mindful of both micro and macro processes, individual and institutional influences and causal powers emanating from both reasoning and resources. Policy initiatives involve a division of labour and a division of 'expertise'. Hjern and Porter (1981, 211) suggested that a 'universal' finding in studies of policy implementation is that clusters of public and private actors are involved.

Consistent with the 'realist approach' advocated by Pawson and Tilley (1997, 158) I adopted a theory driven strategy. The theories explored were the subject matter of the interviews and the informants and survey sample were therefore selected on the basis of their potential ability to confirm, falsify or refine the relevant theories. They were initially drawn from the literature, discussed in chapters one, two and three. As I collected data on the history of community care and personal experiences of policy implementation in each authority I studied, I began to develop and test out my own theories about the relationship between 'context' and 'mechanism' in each area. The actors identified were involved in the implementation of community care policy and the particular initiative, within the context of the Blair government's 'modernisation' programme in their public or professional lives actors or as private citizens. They were politicians, national interest groups, central government civil servants, councillors, senior officers in a local authority social services department, corporate experts, social services strategic managers, planning and contracts staff, operational managers, practitioners, citizens/service users, staff and members of local voluntary organisations and 'partner' agencies. To explore the experiences of and relationships between these groups of actors and institutions, I used a 'networking' approach to identifying potential informants and 'witnesses' advocated by Sabatier (1986). I located the actors involved in policy action in one local authority area and asked them about their goals, strategies, activities and contacts. Their contacts helped identify the local, regional and national actors involved in the planning and execution of the relevant programme. This was a purposive sample. Actors were selected on the basis of their characteristics as potential 'key informants' or 'expert witnesses', their ability to understand the overall conceptual structure and to explore its relevance to their own understanding and experiences and in so doing contribute to its refinement.

Certain individuals were identified on the basis of their relevant individual attributes, knowledge and experience. Their roles were sufficiently singular that their views and knowledge could not be compared with that of a group of peers; these included the minister, leading figures from the department of health nationally and regionally and the co-director of NCIL. Others had the status of 'expert witnesses' by virtue of their substantial experience of and a personal interest in social policy implementation generally, and of community care in particular. All had reflected on their experiences and interests throughout their 'careers' whether as politicians, paid workers, volunteers or end users.

As I carried out my fieldwork within a particular authority, I attempted to interview all the actors identified through the local planning processes as contributing to or expressing an opinion or interest in the case study initiative. I interviewed all the social services managers and planning staff, most care management practitioners and members of the key local voluntary organisations. I carried out a series of interviews with the early 'pioneers', service users who expressed an interest in direct payments. The interviews were dialogues through which to explore their expectations and experiences of direct payments and the other developments in community care policy and to develop a shared understanding of their relevance to the conceptual framework. These informants selected themselves in that they enquired about direct payments and on hearing about my research agreed to meet me.

The data I sought were personal accounts with explanations placed in the context of experience. It was an exercise most people were willing to engage in (with an occasional 'don't quote me' proviso, unfortunately). People often distinguished their 'knowledge' from their opinions, and the latter by those based on direct experience from those influenced by 'hear say' and the accounts of others. They often disclaimed 'expertise' on particular topics under discussion. However they were all interested in exploring and developing 'theories' about the meaning, impact and implications of the policy reform programme and the particular case of direct payments and were not reluctant to challenge what they perceived to be incomplete or erroneous explanations

For the survey (described below), I identified practitioners in the council's own services who could be both affected by the introduction of direct payments and affect their impact, through their influence on local politicians and service users. I selected my subjects through 'stratified purposeful sampling' identifying practitioners from day, domiciliary and community support services (the range of the council's social care provision at the time). The domiciliary service had the largest staff group, I therefore stratified the sample further, interviewing at least three staff from teams working in each of three geographical 'patches' to ensure that they were as representative as possible of the total population.

I also studied all the national and local policy documents referring to the implementation of the particular initiative or the wider policy programme produced during the period of the study.

4.2.4 Data collection

A major advantage of the case study approach is its flexibility and responsiveness to the circumstances and opportunities as they present themselves (Robson 1999). The choice of methods was largely determined by the nature of the subject matter studied and the research questions. However practical considerations were important that is the availability and accessibility of the respondents. I was able to interview some 'national' figures only once. I therefore followed a fairly structured interview guide to ensure that the key points were covered before using a more flexible approach to encouraging respondents to explore the issues that were most important to them. When I knew the time the subject gave me was limited and could not be supplemented by later telephone calls or informal conversations for further information and clarification, I taped the interviews and transcribed them in full. In contrast when I interviewed other actors, whether public servants, voluntary sector representatives or citizens, who discussed their personal experiences and expectations in greater depth, I wrote down their words verbatim during the interview. This helped me in the management and analysis of the masses of data I collected from many hours of interviews. It enabled me to clarify my understanding of the meaning of people's language, phrases and overall accounts with them at the time. People seemed pleased to share their own 'theories' about policy development and implementation. Helping me to record what was agreed kept the discussion of the personal impact of policy issues at the level of thought rather than feeling. My understanding of the usefulness of contemporaneous note-taking, my awareness of the risks of allowing an 'investigative' interview to develop into a counselling encounter and my concern about the ethics of delving into potentially painful emotions without offering any help in their resolution, all owed much to my social work background.

Cost, time and distance meant I was only able to interview some national actors by telephone. However I managed to interview the minister and the Department of Health lead officer in person. I also visited all the respondents in the authority I studied for comparative purposes.

4.2.4.1 Understanding history : written and oral

I researched the local history of the implementation of 'community care'. This helped develop my understanding of the attitudes and expectations of local authority actors when presented with 'direct payments' for community care as a Conservative government policy initiative and if, and in what way, the local response changed as it was adopted and extended by the New Labour government. Martin 1999, and May 1997 both describe how the reminiscences of actors involved in historical events and processes can help explain their contemporary significance. In

Fletcherford I sought to understand the contribution of earlier experiences of policy implementation, and the local policy context, to the later actions of people involved in the implementation of the initiative.

In this recently established unitary authority the lack of documented policies and procedures, emerged as both a cause and effect of the history and practice of community care, from which the new policy programme was to develop. I found that some 'policies' were not written in council reports or procedures, but were 'taken for granted' and implemented as remembered by actors who had transferred from the previous authority (for example policies on charging and resource rationing). I therefore supplemented my reading of written texts, reports et cetera with the 'oral history' accounts of actors who had lived through the development of community care. These included leading local politicians, the first director of social services, managers, practitioners and service users.

4.2.4.2. Being there and taking part

May (1997) suggests that fieldwork is a continual process of reflection and alteration of the focus of observations and questions in accordance with analytic developments. During the first year of my fieldwork I attended all the planning meetings concerned with the introduction of direct payments and made notes. My contribution was usually to provide information on what other authorities were doing, with what results, and to seek answers to particular questions, sometimes by contacting the NCIL, the relevant policy officer at the Department of Health or reading policy documents and reports from elsewhere.

I observed the discussion of direct payments in internal management and team meetings, multi agency planning and implementation groups. I attended meetings on issues of wider relevance to the development of community care and the impact of the government's programme. I also engaged in spontaneous discussions with staff on policy issues, at the time they arose in the course of their work. They were therefore willing to explore and theorise about the relevance of their experiences to their understanding of the means and ends of social policy. In the open plan offices I could overtly listen in to routine conversations between staff, following up my observations with questions that sometimes initiated an informal group discussion amongst the staff around at the time. In these situations, I relayed my understanding of their accounts to the people concerned and this encouraged further reflection and clarification. In the same way, following an interview with a leading councillor, I was invited to join him in the members' lounge. I initiated an informal discussion with a group of long serving Labour councillors on the meaning of the 'third way' and the Blair government's 'modernisation' programme. The purpose was to explore how local policy makers understood and drew on these concepts in their own decision-making and action.

Whyte (1984, 96) proposed that observation guides the researcher to some of the important questions we want to ask the respondents and interviewing helps her to interpret the significance of what she observes.

4.2.4.3. *Interviews*

The interviews were structured with broad themes relating to the development, communication and implementation of community care policy and direct payments. Individuals were also invited to describe and reflect on their own experiences. For example the transition from social services to independent sector home care was described from a different viewpoint by the director of social services, the home care manager and the user representative to the planning groups although the factual details were consistent across these accounts (triangulation). These 'facts' were validated by quantitative information on the changes in the numbers employed in home care, the cost to the local authority, the number of users served and the size of individual care packages. These events had different meanings to each person. Their interpretation of the decisions made and the choices available differed with their own experiences. Along with their reflections on the wider significance of the development of the mixed economy in domiciliary care, these interviews provided data on the actions, reactions and motivation of key actors and their interactions in the policy implementation process.

The focus of my interest developed over the course of the fieldwork on the basis of insights gained from participant observation and earlier interviews, and with ongoing policy developments. After interviews with most of the informants from within the authority area, further discussions were possible as well as single questions for clarification and casual conversations. In most of the interviews with 'local' informants I allowed them to take the lead in deciding which topics, from my list, they felt were important enough or that they knew enough about to talk about in greatest depth. Their preference and the links they made between direct payments, community care and policy developments provided further insights in to the 'layering' of social policies. As with conversations and group discussions, I relayed my perceptions of the accounts given, to the informants during the course of the interviews. This was a way of both checking my own understanding and providing them with the opportunity for further clarification and reflection. Occasionally we would spend a few minutes discussing the exact words to represent properly their opinions, explanations and experiences.

4.2.4.4. *The Survey*

The best source of knowledge of the inner working of a policy programme according to Pawson and Tilley (1967,107) are very often the practitioners '*who have seen it all before.*' Early in my fieldwork I surveyed the opinions and expectations of practitioners whose primary roles were either 'care managers' or 'care providers' in the community care arrangements. All had daily

contact with the public and their services were delivered through their relationships with individuals. This population matched the characteristics of 'street level bureaucrats' as defined by Lipsky (1980,3). I used a quantitative approach to data collection because of the number of actors involved in each category and the opportunity it provided for statistical analysis. I piloted the survey instrument which was in two parts. One was a structured interview schedule with 'open' questions inviting interviewees to describe, as generally or in as much detail as they chose, their understanding of the policy initiative, their expectations and concerns. The second was a series of 32 opinion statements to which they gave 'agree', disagree' or 'don't know' responses and clarifying comments. The overall structure of the 'opinion' statements marked out the area in which the practitioners would make decisions, while revealing what the significant choices and preferences might be. Most were drawn from the debates in the literature representing alternative perspectives on the meaning, purpose and implications of the particular policy initiative, its relevance to the local context and the wider policy programme. Others were taken from the conclusions of a consultation that had been held in the authority three years earlier, which were presented as reporting the views of local people. The informants usually sought clarification and discussed the meaning of the statements, sometimes supplementing or offering an alternative interpretation to those provided by the literature.

The issue of internal validity: the impact of the researcher, the researcher's expectations and the wording of interview questions on the responses elicited was discussed by Burgess (1991, 143). This suggested that practitioners might be wary of discussing their views and experiences if they felt they could be interpreted as hostile to prevalent service philosophies and professional values or revealing ignorance about current social policy. I encouraged them to explore the meaning of these concepts in their own experience and reflect on their own practice, and often recording their deliberations as qualifying comments, before they responded to the opinion statements. For each statement I had illustrative examples that could support a positive or negative response, without revealing the respondent to be either ill informed or 'politically incorrect'.

Furthermore the respondents were aware that the survey was not only for academic purposes. It gave them opportunities to express their concerns anonymously, on a range of policy and practice issues to senior managers in the hope of informing the decision- making processes in the development of direct payments locally. It was therefore not in the respondents' interests to be reticent. . Many already held strong views, based on their considerable experience of community care and reflections on the issues raised, and were keen to express and illustrate them irrespective of any consideration of pleasing or dismaying the interviewer or conforming to management, peer or professional expectations.

4.2.4.5. The Evaluation

I concluded a formative 'evaluation' of the direct payment scheme on behalf of the local authority by the end of the first year of the implementation period. In May 2002 I presented a report to the planning group responsible for the development of the scheme and recommended changes that the authority could implement before a forthcoming 'joint review' (by the S.S.I. and Audit Commission). Practitioners from the new 'integrated care management' teams were interviewed in November and December 2001. The interview schedule included questions about practitioners' experiences of direct payments and of the implementation of the *Modernising Social Services* White Paper.

4.3. Data Analysis

4.3.1. Triangulation

The meanings of triangulation are described by Robson 1999 (290). Triangulation was used in the ongoing analysis of evidence from different *sources* and *methods* to establish the validity of the accounts of the actors and my interpretation of their meaning and motivations.

I considered the perspectives of different actors on particular events and processes (for example accounts of the history of community care in Fletcherford). Subjective accounts were supplemented with numerical data (statistics showing trends in the respective roles of the public and independent sector in domiciliary care with the experiences of the staff and users). I compared my own notes taken in meetings with formal minutes (which revealed not only the priority given to particular issues and decisions, but also to the respective contributions of different participants). I also clarified my understanding of data collected in my observations of meetings with informal conversations.

4.3.2. The survey (quantitative data)

The possible responses to the opinion statements were pre-coded using a statistical package (SPSS) to analyse the results. Differences between the two groups in responses from the expected frequencies were tested using the Chi-square test. This was to establish whether any apparent differences in the responses of the two groups to the statements (whether they agreed or disagreed) were significant at the 5% level of probability. The frequency of responses was counted to assess the strength of support for alternative perspectives on and interpretations of various aspects of community care policy and expectations of the particular initiative. The narrative data elicited by the interview questions was explored and themes were identified. Categories of data were coded for the purpose of statistical analysis. The differences in the responses of the two groups were again tested for significance and counted the frequency with which the themes occurred.

4.3.3. Documents

The content analysis of documents is described by Robson (1999, 272) as an 'unobtrusive measure' in that the nature of the document is not affected by the process of enquiry. He advises that 'documents' usually have a purpose, have not been structured with the needs of the researcher in mind and that the purpose is important in understanding and interpreting the results of the analysis. The purposes of the documents I analysed were to explain the objectives of particular initiatives (ends), the reasoning underpinning them (theory) and to provide instructions for implementation (means). Some documents suggested how policy effectiveness would be judged (performance indicators).

I explored central government policy documents and guidance for coherence with the wider policy programme, for instances of lack of clarity and inconsistency in the direction given and for use of theoretical language and concepts. Their relevance to the actions and decision making of individuals and interest groups was considered. The objectives and imperatives presented by central government were identified and compared with the interpretations and priority given by the various actors in the implementation process.

4.3.4. Interviews and group discussions

Thematic analysis (Robson 1999, Silverman 2000) involves organising interview material in relation to specific research questions and to the issues of informants. I word processed my transcribed tapes and handwritten notes at the earliest opportunity, gradually developing and refining categories to identify the relationship between features of the historical, policy and political context and the actions, reactions and understanding of individual actors. I analysed the themes identified in terms of their relevance to the conceptual framework and whether they confirmed or refuted theoretical propositions.

I began by familiarising myself by reading and re-reading the data. I 'immersed' myself in the data and in order to organise it into categories, classified it on the basis of themes, concepts and similarities. The relationships between concepts were identified. Categories were assigned to data through increasingly refined coding and related categories to each other from the context in which they occurred. Coding categories of data involved identifying bits of meaning and breaking up the data in analytically relevant ways. Silverman (2000) described four flows of activity in data analysis. The first, data reduction refers to the process of selecting, focusing simplifying abstracting and transforming raw data. My raw data was organised through the method of data collection (for example answers to interview questions). The second flow refers to 'displaying' data that is assembling it visually to clarify the main direction and missing links in the analysis. This was done through the use of matrices and flow charts relating the data to wider concepts, linking categories to each other and possible explanations in theory. The first

two flows of activity informed further data collection, suggesting themes, issues and apparent relationships between variables that needed further exploration.

When I initially typed up interview notes, I did not have pre-defined categories. I trawled through the data exploring for patterns, critical terms and key events. I indexed and organised all the data in this way as I collected it. Therefore when returned to the accumulating data and eventually explored all the data collected, an initial set of categories existed. Through more focused reading of the data I located additional categories and sub categories. Changes to existing codes emerged during the ongoing data collection process. Core themes emerged. Finally I scanned the data and existing codes for illustrative examples, making comparisons and contrasts. Themes linked categories as I became completely familiar with the data, both relating to the research questions and emerging from the data. I compared my findings to established theories about policy action and individual agency (elaborated in chapters one, two and three), to compare themes to key analytical concepts and to look for similarities, differences and absences in the data. I reworked relationships between categories and refined and developed themes gradually testing out explanations for my findings.

4.3.5. Observations of planning groups, meetings, and informal discussions

I took notes making memos in context. As recommended by Silverman (2000), I typed them up immediately placing the content in broad categories. I returned to these notes to modify and develop the categories as their wider relevance to other data was confirmed. In all these situations, key issues and tensions were highlighted. Firmer explanations of the way in which decisions were made, conflict between objectives was reconciled and the ends and means of policy were re-negotiated by actors as the implementation process gradually developed.

4.3.6. Drawing conclusions

The third flow of activity described by Silverman (2000) is drawing conclusions. This involved proposing meanings and noting regularities, patterns and explanations. The fourth activity is verification, testing provisional conclusions for their plausibility, confirmability and validity. This included bringing in data from a second local authority to the analysis to confirm the validity of my conclusions. All the above data was analysed, noting themes relevant to theoretical propositions and relating these to the research questions. I developed my account of the complexity of the implementation process, interpreting the themes I identified with reference to the theories and research findings reported in the literature and showing how they interacted in the case under study in two different local authority contexts.

4.4 Discussion

My research was concerned with evaluating an approach to securing policy success, while revealing some aspects of the complexity of the policy process. This contributes to knowledge about the limitations of policy evaluation research that attempts to inform action and improve policy 'effectiveness' without opening the 'black box' to discover what might work for whom and in what circumstances. However my fieldwork used an ethnographic approach to witnessing and engaging with the lives of research subjects. The advantage of this was to bring me closer to the reality of how formal laws, rules and procedures interact with informal values, norms and beliefs to influence behaviour in organisations. My fieldwork in the 'real world' situation of those engaged in and affected by policy action provided me with data on how constraints on behaviour were mediated through official and unofficial power structures. Explanations were sought of the '*real engine for change in social programs*' identified by Pawson and Tilley (1997, 46). That is the process of differently resourced subjects making choices amongst the range of opportunities provided.

The now classic 'muddling through' explanation of the policy making provided by Lindblom (1959) asserted that the means and ends of policy are often chosen simultaneously, during the execution process. Therefore Smith and May (1980) suggested that the presence or lack of a sequential relationship between means and ends may become more apparent when several stages of the implementation process are examined together and overall. Being present during the planning and early implementation process enabled me to observe the relationship between the policy objectives set and the ways identified for achieving them, how 'means' and 'ends' were interchanged in practice and how those involved understood and explained the decisions made.

CHAPTER FIVE

Policy Making, Politicians and People

'I want to renew faith in politics by being honest about the last 18 years. Some things the Conservatives got right. We will not change them. It is where they got things wrong that we will make change.' (The Labour Party Manifesto 1997, 1)

5.0 Introduction

An account of the process that led to the policy decision to introduce direct payments in the northern town of Fletcherford begins the empirical exploration of the *'links and interactions between policy interventions, the cumulative impact of policies and the influence of institutional regimes'* (Sanderson 2000, 439). The process began with the permissive legislation of Major's government (Community Care [Direct payments] Act 1996) that empowered councils to make direct payments from 1997. It culminated three years later in Fletcherford council's decision to use that power in response to the promotion of the initiative by Blair's government (Dept of Health, 2000a). From an alternative perspective, this process began with the campaigning efforts of disabled people who persuaded some local councils to make 'direct payments' through third parties. The 1996 Act responded to the success of these schemes in achieving the outcomes of user satisfaction and cost-effectiveness (Zarb and Nadash 1994), by containing direct payments within the parameters of community care policy. The attitudes of Fletcherford people (politicians, workers in the public and voluntary sector and service users and carers) to direct payments are explained within the context of their beliefs about 'community care' and their experience of its implementation as a Conservative policy.

Direct payments, as a Major government initiative, were rejected in 1997 by Fletcherford's Labour council, following a consultation with local people. With the endorsement of the Blair government, direct payments eventually became part of Fletcherford council's own modernisation programme. In this account, the reasons for this change in a local authority's policy are revealed as more complex than filial loyalty to the party in government. The interactions between 'top-down' (central government) and 'bottom-up' (local staff and service users) influences are described. These influences were mediated through the opinions of local politicians, their beliefs about the ideological objectives of national policy makers and about the expectations and motivation of service users. Public servants played a key role in presenting and interpreting the messages from 'above' (the government) and 'below' (the people) to local policy makers.

A description of Fletcherford locates the introduction of direct payments in a historical and political context. Because it was a 'new unitary' authority Craig and Manthorpe's (1999) research into the impact of local government re-organisation on the work of social services is referred to, where it is relevant to policy implementation in Fletcherford.

The findings presented in this chapter are based on the following:

Table 5.1 Data sources and contribution to policy- action process

Source	Contribution	Methods and dates
National		
Central government policy documents and directives	Guidance on central government policy and implementation	Documentary Analysis Sept.1999 to Aug. 2002
John Hutton	Health Minister responsible for the extension of direct payments	Interview June 2002
Lead officer (seconded) for direct payments .	Department of health (national)	Interview April 2001
Frances Hasler, Co-director of the National Centre for Independent Living	Voluntary organisation funded by the Department of health to support the development of local direct payment schemes	Interview June 2001
3 senior staff in the Department of Health .	Civil Servants with lead responsibilities for developing policy and practice guidance	Telephone discussions Feb. 2000, May + June 2001
Information staff at the N.C.I.L	See above	Telephone discussions March, April, June + Sept. 2000
Regional Inspector (Performance)	Department of health/ SSI officer	Interview April 2001
Fletcherford		
Policy statements, council reports, meeting minutes, consultation records.	Reports informing and recording outcomes of local decision making processes in implementation of direct payments	Documentary Analysis Feb. 2000 to May 2002
Deputy Leader	Local politician (Labour group)	Interview March 2000
Board member for social services	Local politician (Labour group)	Interviews April and May 2000
Former vice chair of social services	Local politician (Labour group)	Interviews Feb.+ March 2000
Chair of Scrutiny	Local politician (Labour group)	Interview April 2000
Labour councillors	Local politicians (Labour group)	Group discussions April 2000
Senior management team social services	Meetings to discuss reports to councillors	Observation Feb. to May 2000
Management Information Team	Officers responsible for central performance monitoring returns	Group discussions April to July 2001
Former assistant director (SSD)	Led the first consultation on direct payments.	Interview October 1999
Director (SSD)	Fletcherford Chief Officer	Interviews April + Aug. 2000
Chair of day service user group	Involved in initial consultation on direct payments	Interview July 2000
Day service users	Involved in initial consultation	Group discussion July 2000
62 practitioners	Community care staff	Survey April to Aug 2000
Planning, review + policy managers	Social services officers with policy implementation responsibilities	Conversations Feb to August 2000

5.1 Background, Community Care Policy in Fletcher ford

Fletcherford is a unitary authority created in 1997. With a declining population of just over 90,000, the proportion of older people has been increasing. Less than one per cent was from minority ethnic groups. There were relatively high levels of disadvantage, reflected in health and social care needs. Fletcherford was a geographically 'isolated' urban area. Fletcherford council enjoyed some of the advantages of the change to unitary status identified by Craig and Manthorpe (1999), along with the financial pressures associated with lost economies of scale and formula based central government funding. Strong popular identification with the town meant that people understood which authority served them, without the confusion reported elsewhere. The abolition of the county tier reinforced 'natural' boundaries and community affiliations. As a smaller authority it had more potential for reducing bureaucracy and improving communication and accountability, from and to local councillors.

Fletcherford had several voluntary groups for disabled people supported by an umbrella organisation and a Voluntary Sector Development Agency. These groups were focused on representing and supporting their very local membership rather than providing community care services. They may have had difficulty broadening their membership beyond rather narrow 'communities of interest' for representational purposes (Barnes 1999). However these small organisations seem not to have experienced the conflict of business and user interests suffered by locally 'grown' voluntary/ interest groups identified by Priestley (1999) in the post 1993 'contract culture'.

The new authority developed a 'pragmatic approach' to the market for community care. This began in its first year of administration. A rebellion within the Labour group of councillors appeared to symbolise the tensions between New Labour's policy on the mixed economy and the 'Old' Labour commitment to collective provision and the protection of jobs and services, found for example in Pearson's (2000) study. Fletcherford council began with a budget deficit for social services. Its own residential homes, facing independent sector competition, were costly to run. A report to the politicians recommended exploring alternatives to the authority continuing to provide residential care. Some Labour councillors argued that action should be postponed until the recently appointed commission on the funding of long term care reported (Sutherland 1999). They predicted (correctly) that Blair's government would remove the perverse funding incentives in the benefit system that disadvantaged public sector provision. A minority defied the 'whip', voting against the proposal to consider 'contracting out' residential care. The rebels were suspended temporarily from the Labour group. Nevertheless the majority ultimately decided that the council should withdraw from the provision of residential services, an apparent victory of pragmatism over ideology.

Other developments in community care provision in Fletcherford reflected trends in policy implementation nationally and influenced the expectations of future policy change expressed by Fletcherford councillors, service users and practitioners. These included the introduction of means tested charges for non-residential services, the reduction in the council's home care provision; the expanded role of the independent sector and the gradual dismantling of centre based day care.

5.2 Fletcherford's response to direct payments as a Conservative government policy

In April 1997 local authorities were given powers, but not duties, to make cash payments for community care by the Conservative government¹². By November 1998, when the New Labour government published the White Paper *Modernising Social Services*, only 31 councils were using those powers to make direct payments and only one thousand people were receiving them (Dept of Health 1998a, 2.14). In 1998 Fletcherford was one of the authorities with no plans to introduce direct payments, and would be one of the last nine English councils to do so.

5.2.1. The 1997 consultation

In the summer of 1997, policy and planning staff in Fletcherford social services embarked on a consultation exercise to explore local interest in direct payments. My fieldwork began with a review of the data collected and the conclusions drawn from this consultation, as reported to the social services committee. Officers and users who had participated and five councillors to whom the director of social services had reported were interviewed. The former Assistant Director who had led the consultation and a planning officer who had been involved provided accounts. Operational staff who had been in post in 1997, but were not consulted, were also interviewed.

I reviewed a list of forty local voluntary groups that had been sent a questionnaire, seeking their opinions on direct payments, and thirty-one completed questionnaires. Seven basic questions were asked with a possibility of a "yes", "no" or "not sure" response. There was no evidence that supporting information had been provided and so it was unclear how informed the opinions expressed were by knowledge about direct payments. The questionnaires did not ascertain whether the respondents needed or used community care services, or whether they sought the views of the membership of their respective organisations. Fifteen of the respondents indicated that they did not think that direct payments were a good idea. Because of the 'tick box' nature of the questionnaire, there was no room designated for comments. Nevertheless seven of the 'negative' respondents added that they agreed with the principle of direct payments if support was available, although they would not personally use them.

¹² The Community Care (Direct Payments) Act 1996

Alongside this small survey, there were notes of two consultation meetings. One took place at a day centre for people with physical disabilities, attended mainly by people too old to meet the original age criteria for direct payments¹³. Only ten service users attended, from a potential population of over eighty. The notes taken suggest that the users expressed concern about the responsibilities involved in direct payments and were also keen to inform senior social service managers how much they valued the day centre. My later discussions, with eight of the people consulted at this meeting, revealed that they had perceived direct payments as a potential threat to the day centre. This was because other council run centres were either closing or changing their function. Users suspected that senior officers 'from the civic centre' were trying to promote direct payments as a way of breaking down the collective nature of existing provision and to undermine the strength of potential resistance from users united as a group.

The users involved told me how, following the meeting, they approached the staff and asked if they would be willing to form a co-operative to take over the centre if the council decided to close it. The users' idea was that they could then pool their direct payments to fund the service:

'I would continue to come here [day centre] if I got direct payments.. So this could be run as a co-operative. At the consultation meeting we expressed very strongly the importance of the social aspect along with welfare to work. For me, coming here means I am contributing, helping to organise events...' Chair of the day centre users' committee

However the day centre staff told me that they declined this proposal from users, preferring to await the outcome of a service review before making any commitment to change. They were reluctant to jeopardise their rights to severance payments based on continuous service with the council

The findings of the consultation with day service users were summarised as follows:

'Consensus that system onerous and recipients' responsibilities a burden. Likely to appeal to those who are dissatisfied with mainstream social services.' (Report of Director to Social Services committee, October 1997)

There were notes of a second forum attended by parents of disabled children, who were not eligible for direct payments under the original criteria. These parents took the opportunity to raise their concerns about the lack of a day service for younger disabled people in Fletcherford. The results were summarised thus:

'Consensus that Direct Payments would only be applicable for a very small number of people in Fletcherford. Not appropriate for most of group members' dependents.'
(Notes of the consultation meeting)

¹³ 18 to 65 years

The assistant director who chaired these meetings suggested that the discussion reflected the 'paternalistic culture' in Fletcherford. He reasoned that people trusted the authority to arrange their care and were concerned to protect traditional services. However the planning officer's impression was that the councillors did not want direct payments and that as officers they were just '*going through the motions*'. In her view '*the members did not want it and we did not want it, so we decided to keep it low key*'. That is they did not attempt to raise general awareness of the possibility of direct payments.

In October 1997 the outcome of the consultation was reported to councillors. The report stressed lack of interest amongst service users and their concern about the 'onerous' responsibilities of managing direct payments. The recommendation, that the matter should be shelved to be reconsidered in 1998 the light of national developments, was accepted. Two leading councillors remembered that when they were advised that nobody wanted direct payments this had confirmed their expectations. One felt that people would be deterred by the paperwork involved; the other feared that there would be opportunities for abuse and misuse of the money. They both worried about the potential effect on in-house 'home care' provision, because direct payments could not be used to buy council services. This concern about the threat of 'back door privatisation', expressed by 'Old Labour' councillors, was to re-emerge when the issue of direct payments was raised again in New Labour policy documents (Dept of Health 1998a, 2000a).

5.2.2 Comments on the 1997 consultation

The consultation was carried out by planning staff. They had no background in social work, or direct contact with users of community care services. Operational managers were made aware of the new legislation and that a consultation was taking place, but were not involved. One fieldwork manager confided that he felt that operational staff had breathed a '*sigh of relief*' at the decision to postpone action on direct payments, because of their uncertainty about the impact on their work of an initiative being considered without their input.

Almost half the responses to the postal questionnaire were positive, which if taken as an indicator of potential take up would have been high relative to the national picture. However there was no indication that the respondents to the postal survey were representative of the eligible population. Both consultation meetings were targeted on groups where the majority would not be eligible for direct payments under prevailing rules. Those community care users who were consulted used the exercise primarily as an opportunity to express their satisfaction with existing provision to senior managers, believing they were protecting jobs as well as the centre-based service.

A more relevant indicator of potential demand for direct payments locally would have been use of the Independent Living Fund, the trust established by the Government in 1988 to make direct

payments for care to disabled people. Take up levels for direct payments from the I.L.F. in Fletcherford were significantly higher than the national average. For the original 'Extension Fund' it was 19.1 per hundred thousand population compared to 11.5 average for England between 1988 and 1993. For the '1993 Fund' it was 15.7 per hundred thousand population compared to the 10.9 average, between 1993 and 1998. There was therefore no reason to presume that Fletcherford people would not be interested in direct payments from social services. Community care practitioners were aware that the Independent Living Fund was already making direct payments to local disabled people. However they were not consulted, despite their regular contact with users. One social worker reported that she had received requests for direct payments since 1997. She had repeatedly informed managers about this interest but had been told that there were no plans to introduce direct payments. Only four of the 62 practitioners I interviewed were aware that this consultation had taken place.

Analysis of the documentary evidence (the data collected and official reports of the outcome), along with discussions with social service staff, suggests that the 1997 consultation was a token exercise. It was undertaken by planning officers, who expected political and managerial resistance to the initiative and so made minimal efforts to establish whether there would be any local demand. Nevertheless the council solicitor who was aware of the consultation, felt able to say, when the direct payments issue was raised again in 2000, that local people had "rejected" the option. Councillors had been relieved to learn that local people were not interested in the latest Conservative government community care initiative. Service users who were aware that a consultation had taken place were similarly convinced; *'To be fair they did a consultation and got a luke warm reception so you can't blame the local authority..'* (User representative to direct payments planning group). The result of the 'low key' approach to consultation taken in 1997, was to reinforce the impression that direct payments were a marginal issue in Fletcherford.

5.2.3. Discussion

Councillors seem to have accepted the conclusions of the consultation report because it fitted their preconceptions about the views of users. Officers presumed the Labour council would not support this Conservative government initiative, so they carried out a very modest consultation (largely consulting people who seemed unlikely to be affected) and reported what they perceived would be the preferred outcome.

Councillors expressed three objections to direct payments as a policy initiative introduced by the Conservative government. The first concern was that service users generally would be deterred by the prospect of keeping records. This could be explained by what has been described in the literature as the 'care discourse', which understands disabled people as dependent and

unable or unwilling to manage their own affairs (Morris 1997, Oliver 1991, Priestley 1999). The second concern about the risks of abuse could be associated with what Pearson (2000) described as a 'market discourse' and 'scroungerphobia' which she found prevailed in a Conservative led council during the implementation of direct payments. The third issue raised by councillors was the potential impact of direct payments on the demand for in-house home care provision. This is relevant to Pearson's analysis of the 'social justice discourse' prevailing in the 'Old Labour' authority she studied, where direct payments were not available when they appeared to threaten council jobs and services. The views expressed by the local politicians can also be explained by the 'knights, knaves and pawns' theories of human agency in welfare services discussed by Le Grand (1997). Some councillors perceived community care users as passive 'pawns', vulnerable to exploitation by dishonest 'knaves' in the social care market place and so in need of the continuing protection of the honourable 'knights' in public services.

The people who attended the consultation meetings in 1997, overtly opposed the idea of direct payments, as it was presented to them as an 'individualist' service model that threatened the collective provision of day services. However some users perceived their potential as a means of defending a collective service, if their use was based on co-operation between day centre users and staff. Rather than pursuing the option of direct payments as a consumerist strategy that would give them purchasing power to arrange individual care packages through the community care market, they appear to have taken the initiative as the 'reflexive citizens' of Giddens (1998, 2000) thesis. They sought to challenge the council's power to close their day centre, with their own judgement as to the appropriateness of the service to their needs. They approached centre staff with a proposal to use direct payments to secure the future funding of the service. It was the staff's preference for remaining in local authority employment that deterred them from pursuing this proposal further.

5.3 New Labour and Direct Payments

5.3.1 From the top, down? Central government's approach

The Labour government presented its plans for '*Modernising Social Services*' (Dept.of Health 1998a, 2.14 to 2.17), late in its second year of office. The White Paper expressed the government's support for direct payments and its determination to ensure their expansion. Cash for care was no longer just a Conservative policy associated with the ideological, rather than pragmatic, use of the market and imposed economies in public services.

John Hutton, the minister with responsibilities for direct payments between 1998 and 2001, explained why the New Labour government adopted this policy initiative of the Conservative government:

'It looked to be an effective way of transferring power and responsibility to people who needed to use social services.... I think the basic structure of direct payments and the way they operate looked much more in tune with modern society than the 'take it or leave it' monopoly, monolithic nature of much publicly provided social services. It puts the boot onto the other foot.' (John Hutton, in interview June 2002)

Hutton explained that his own primary objective was to ensure that disabled people enjoyed an improvement in the quality of service.

'What matters to me is the quality of service they get. I am fundamentally not interested in preserving bureaucracies and organisational structures.' (June 2002)

The minister did not regard direct payments as a way of saving public money through reducing the pay and working conditions of care staff. However he recognised that unions might be concerned about the implications of people moving from public sector employment to work for private individuals.

'I am not about to engineer things so that terms and conditions of support workers go through the floor, and people get ripped off and so on... but at the end of the day it is the needs of the disabled person that must always come out on top, not the needs of any organisation, trade union or vested interest of any sort. It has to be the needs of the person themselves.' (June 2002)

The minister also acknowledged the influence of disabled people on the development of his own views on direct payments:

'I think the disability movement itself is going to be a very important advocate for change here. I was always struck by how strongly in support of direct payments disabled people are. That is where a lot of the drive will come from for more progress. I hope governments will continue to listen to those concerns and to act upon them.' (June 2002)

Frances Hasler co-director of the National Centre for Independent Living described how the government had provided funding for this organisation run by disabled people to support local user groups and councils in developing direct payment schemes across the country. Her perception of the minister's attitude to direct payments, and his approach to consulting disabled people, supported his own account:

'John Hutton is very for direct payments and enthusiastic. He is convinced by the arguments.... He is interested in what we had to say, genuinely sees it as part of modernising and getting away from monolithic local authority provision.' (Frances Hasler in interview June 2001)

However not even the views of disabled people had yet convinced the minister that the choice of a direct payment should be extended to health care. Equality took priority over individuality.

'I know some, many people in the disability movement like the idea of direct payments coming over to health services, of being able to shop around... I think there are

different issues with health. I think we need to be quite careful about that. We have to treat everyone equally first. ' (John Hutton, in interview June 2002)

The Labour government's first proposals for extending direct payments, were heralded in draft in September 1999 and effective from February 2000¹⁴. The guidance continued to exclude powers to make direct payments for health care. When this led to requests for clarification from care managers responding to requests for direct payments for people with both health and social care needs, a department of health civil servant explained :

'The ministers were asked if they wanted to allow pooling funds for health and social care to be used as direct payments. They did not want that, they thought it would be the "thin end of the wedge". The issue from my point of view is not charging for health care. It is the principle of the collective versus the individual and equity in the National Health Service. Ministers were concerned about NHS money going into an individual and private relationship..., outside of the NHS. I think in a year's time it may change.' (Civil servant Dept. of Health 'health care group' June 2001)

The new guidance announced the extension of the eligibility criteria for direct payments to almost all adults with assessed needs for social care services.¹⁵ It confirmed the government's intention to ensure that this option was extended nationally. Local authorities were obliged to assess individual applications for direct payments. They could no longer refuse requests on the grounds that they did not 'do' direct payments, whether or not they actually ran a 'scheme'. By the time new guidance was issued, 80% of local authorities said that they intended to introduce direct payments (JRF 2000). Councils without plans to implement the initiative appeared to be considering the implications of New Labour's approach. This was in response to the perceived pressure from government and the bolstered role of the Social Services Inspectorate in monitoring performance against government objectives:

'Government gradually became firmer in terms of its expectations ... exhortation by ministers and asking us to lean on them.' (Social Services Inspector, in interview, April 2001)

In 2001 The Carers and Disabled Children's Act extended the powers of councils to make direct payments to carers and to the parents of disabled children. The Health and Social Care Act 2001, effective from April 2002, consolidated existing legislation¹⁶, extended eligibility further and made the provision of direct payments mandatory. Direct payments were included in the central performance assessment framework from the autumn of 1999, as one of the measures through which the Department of Health Social Services Inspectorate reported on the

¹⁴ *Community Care (Direct Payments) Act Policy and Practice Guidance,*

¹⁵ Who are willing and able 'with assistance' to make their own care arrangements.

¹⁶ The same statute developed the themes of the 1998 White Papers and the 1999 Health Act, promoting effective partnerships between health and local authorities, removing legal obstacles to joint working and demanding that citizens enjoy fair access to 'seamless' health and social care.

achievements of individual councils (Referrals, Assessment and Packages of Care Returns). However councils were left with the power to decide eligibility in individual cases and whether, and how, they would provide support for people receiving direct payments.

Early in 2001 an officer from a London borough, with experience of direct payments, was seconded to the Department of Health to assist the civil servant head of the Social Care Group in promoting implementation. To that end, they both travelled North to run seminars for local authorities in March 2001. The mere offer of this extra 'help' from the Department of Health appeared to have the desired effect:

'North East and North West regions [were targeted] only. This was purely on take up and the number of local authorities without schemes. In the North East more councils were saying they had not yet got schemes up and running than North West. By the time of the events, none were still saying that they were not intending to do it.' (Dept of Health lead on direct payments)

The Department of Health continued to fund the National Centre for Independent Living to assist both councils and local support services in developing and extending the use of direct payments:

'As pioneers we were being asked to support others. We already had a design for a National Centre for Independent Living, then we had a member on the technical advisory group. We asked the Department of Health to fund the work.... They wanted to support local authorities, NCIL wanted to support the disabled people's movement. Our role in a broad sense is to support Independent Living, specifically to provide support, consultancy and training' (Co-director of NCIL, in interview June 2001)

Alongside other disabled people's organisations, NCIL was invited to help in the development of guidance material.

'We tried with the new guidance, with the wording, to make it easier for people to get direct payments, we consulted with users' groups' (John Hutton, June 2002)

5.3.2. Discussion

The minister used third way 'modernising' language to explain his government's promotion of direct payments. He endorsed the objectives of both empowerment and choice through competition (in his rejection of 'monopoly' in service provision). He acknowledged social justice issues in insisting that the government's intention in promoting direct payments was not to undermine the pay or conditions of care staff. Nevertheless, the minister prioritised the rights of disabled people before the interests of public services and staff, which showed a preference for the 'individual' over the 'collective' in the social care field. However he would not accept an individualist model in health services. Instead social justice considerations, ensuring equality in access and treatment, came before the choices and empowerment of individuals. That was despite the minister's own declared commitment to heeding the wishes of disabled people and

the efforts made by the national government to collaborate with the independent living movement in the development of the initiative.

5.3.3 Direct payments in Fletcherford under New Labour

The chair of the Fletcherford day service user group explained how community care policy had been regarded suspiciously by local disabled people before the Blair government endorsed it:

'For the Conservative government, community care was a way of privatising health and controlling the costs of social care through pushing them back to local government. The split [between health and social care] is political rather than practical. A utopian ideal of independent living would have worked if they had given enough support. But under Tories the move from hospital/ health to community/social care was about cutting costs.' (Interview December 2000)

The issue of direct payments was not brought back to the social services committee in the summer of 1998, as recommended in the 1997 report to councillors. However it re-emerged following the publication of the White Paper (Dept of Health 1998a). By early 1999 senior managers in Fletcherford social services were considering how they should resurrect the issue of direct payments and had begun discussions with the Centre for Applied Social Studies at Durham University about commissioning independent assistance with implementation. There were changes in key personnel in the division responsible for planning. A new assistant director was recruited from the Department of Health and was particularly interested in policy implementation and the council's performance in achieving centrally set objectives. A new planning manager came with experience of and a particular interest in direct payments and user involvement.

Under New Labour councils in the North were expected to co-operate:

'In 1999 my colleague did an inspection of services ... in a neighbouring town. They were not doing anything on direct payments. We got heavy with them, told them to introduce direct payments as part of a strategy for empowerment. By Autumn 2000 I monitored and found that 17 people had approached asking for direct payments. So that showed there is an appetite for direct payments in this area, any differences were down to politicians and managers.' (Social Services Inspector, in interview, April 2001)

Fletcherford social services also found that there was renewed interest from the SSI inspector:

'I saw the director of Fletcherford and said it was not acceptable. Other areas were not moving fast but were trying. I had to be more influential than the legal department, empowering him to go to committee My criticism was in support of the director. Before then there was not the will power.' (April 2001)

The SSI inspector said that central government was trying to secure commitment to its objectives through the monitoring of performance against objectives. He believed that the fear of publicising poor 'results' had more effect on behaviour of local authorities than the threat of

the secretary of state removing the powers of under achieving authorities to continue to run their own services;

'The Health and Social Care Bill, gives secretary of state powers to step in. But the role of secretary of state is not as powerful as it seems... It would be very difficult in practice to divest a council of its powers.' (April 2001)

When direct payments were raised again with councillors in Fletcherford, they were rejected but a detailed report was requested. There was some debate between the assistant director, the strategic manager and the planning manager about how local politicians should be persuaded to agree to the introduction of direct payments. The senior officers prepared arguments to convince Labour politicians of the merits of the initiative. The strategic manager offered the position that that this was no longer a Conservative policy, *'not back door privatisation'*. The assistant director argued that it was something the authority would ultimately be compelled to do and that it was already under pressure from the SSI. The planning manager preferred to stress that direct payments were a policy initiative with roots in the disabled peoples' rights movement. (Observation of discussion, March 2000)

The director presented the report to the council and attempted to "sell" direct payments with the assurance that their impact would be marginal, *'I told them only ten mental health service users in the country are actually getting direct payments.'* (Interview, April 2000). There was no further consultation with local people. Nevertheless a minority of Labour councillors continued to oppose the initiative. Within the Labour group, they argued that direct payments represented a step towards the local authority relinquishing its responsibilities to make collective provision for those in need of care and support. One councillor described it as the *'thin end of the wedge'* (March 2000). The opponents, who were ultimately outvoted, explained their reasons in interviews (April 2000). The deputy board member for social services likened it to the *'Tory idea of nursery vouchers'*. The chair of the scrutiny committee voiced concerns about *the 'ideology of consumerism'* and *'the second class status of social service clients'* in the social care market. He foresaw that people receiving direct payments would not feel empowered because they would not be free to spend their care budgets as they wished. They would therefore feel stigmatised by social services budget limits, charges and monitoring procedures, unlike people who could afford pay for their own care without undergoing a means test or accounting to the council for spending decisions. Another councillor argued that the introduction of direct payments was intended to undermine public services, particularly home care, because users could only use their spending power in the independent sector. He drew a parallel with the introduction of the *'mixed economy'* with the implementation of community care policy in 1993, when councils were obliged by the Conservative government to spend 85% of their community care budgets in the independent sector.

I led a discussion with a group of leading Labour councillors on the topic of New Labour's plans for 'modernising' public services (April 2000). Most said that they already accepted that the requirement that councils test their spending for 'best value' (DETR 1998) would lead to a major rationalisation of in-house home care. Private sector agencies would take over most general work. They argued that the council would be powerless to resist this because of financial problems inherited when Fletcherford became a unitary authority. Just as when they had made the decision to 'externalise' residential care services, the majority of the Labour group took a *pragmatic* approach to the market. They accepted that securing the amount of provision required through the private sector would be achieved at the expense of the quality of service experienced by users. None expressed any doubt that council 'home care' staff were better paid, trained, vetted and managed and provided higher quality services than their private sector competitors. All the Labour councillors interviewed asserted that social care service users, if given the choice, would prefer to continue to receive the council's own home care provision. However, all but three, felt that this would not be an option the authority could continue to offer. That was because the pay rates and conditions of service enjoyed by council workers were above national minimum levels and so would make private sector domiciliary care cheaper and appear to be the 'best value'. They presented anecdotal evidence of the poor quality of services provided by private sector agencies and of the dissatisfaction expressed by people they represented. They believed that the government's 'modernising' initiatives prevented them from terminating contracts with private sector agencies on the grounds of quality considerations.

One leading member, who said he supported the principles of user participation in decision-making and individual empowerment, nevertheless opposed the introduction of direct payments. He explained that this was because he did not think these objectives would be achieved within the constraints of the central government's rules and criteria for direct payments. He was also sceptical about professionally managed consultation and planning exercises genuinely informing and empowering people. An initiative imposed by central government and implemented by professionals was not likely to engage and enthuse local people.

'I'm worried about element of tokenism and 'voodoo professionalism', the use of professionalism to hide the truth and bamboozle... People learn and grow through participation. There is capacity within people, with encouragement, to become community leaders and service developers within their communities'.
(Scrutiny Committee Chair, in interview, April 2000).

The majority of Labour councillors were in favour of the introduction of direct payments by 2000. They justified this initiative as a way of 'compensating' users dissatisfied with poor quality independent sector services. They felt that money would give users the option of rejecting private agencies and employing staff of their choice instead. Nevertheless the belief that people would not want the extra work involved in keeping records and worries about abuse

and misuse persisted. Opposition continued from key figures in the Labour group. Their concerns were expressed at interview, as the need to balance the two imperatives of empowering users while protecting collective provision. Morality and motivation in a social care market continued to be their main concerns rather than individual empowerment, although they recognised the lack of choice and control experienced by users identified by their fellow councillors. Despite the misgivings of the minority of Labour members, there was ultimately no open rebellion. In April 2000 the council accepted the recommendations of the Director of Social Services that the development of a direct payments scheme for Fletcherford should be delegated to planning groups involving a range of potential users.

In the election of May 2000 no political party won overall control and, till 2002, policy implementation continued through the decisions of a 'hung' council. Liberal Democrats and Conservatives formed a coalition. The director of social services' view was:

'They have been naive, they have no policies, they did not think they were going to win. They will just go with the existing strategy. I think pragmatism will rule, I am not aware of any deep malaise at the political level. They will all work well with officers' (May 2000)

He lamented the move to cabinet style executive that meant that only three councillors remained involved with policy decisions in social services, one from each of the three major parties:

'The down side of Modernising Local Government is the loss of committees, now only a handful of members know anything about social services and they lack of awareness of the modernisation agenda, it is not how it was with community care.'

5.3.4. Discussion

The issue of direct payments was resurrected in Fletcherford after the Blair government promised to extend their availability (Dept. of Health 1998a). This 'top down' pressure coincided with the appointment of individuals with interests in the implementation of this initiative to key posts in Fletcherford. Officers anticipated and addressed councillors' continuing ideological objections. The language of the mixed economy was avoided in reports to members (competition, choice, care market, potential for cutting costs) although these concepts were regularly used in discussions amongst senior managers. References were frequently made in informal conversations amongst officers to the pressures of reconciling central performance objectives, political allegiances and users' attachment to collective provision and values. Councillors were also encouraged to expect that there would be little interest in direct payments locally. In 1997 consultation appeared to have been used to justify inaction. In 2000 the decision was made to introduce direct payments and demonstrate commitment to a New Labour initiative, without further attempts to establish opinions or potential interest amongst local community care users.

Direct payments were sold to the Labour council in Fletcherford as a 'New Labour' initiative with a history predating Tory policy, and roots in the disability rights' movement. Despite the continuing commitment to both collectivist values and municipal paternalism amongst Labour councillors, direct payments were accepted as a pragmatic necessity. Councillors also saw them as a way of giving social care users, denied high quality public services, the opportunity to arrange their own care rather than relying on private sector providers motivated to pursue profit rather than social justice. For local politicians the pragmatic use of the market in community care advocated by New Labour (Dept. of Health 1998a) did not mean what worked for users but what was affordable for the public. Rather than supporting New Labour policy objectives, they felt unable to resist them. As public purchasers (agents) these councillors believed they were obliged to decide on the basis of price. This exposed the weaknesses of the market as a mechanism for efficient resource allocation in social care. Politicians were aware that private sector domiciliary care was not meeting user need to a satisfactory standard. However the interests of the agents /public funders took priority over the interests of the principals/ end-users.

One leading Labour councillor, who continued to oppose the introduction of direct payments, advocated an alternative model of empowerment, through collective activity rather than individual choice and consultation. He argued that the government's approach was not likely to achieve wider objectives of empowerment and that users do not have sufficient knowledge to exercise real choice and control. This seasoned politician's analysis of alternative approaches to involving and empowering users was based on his own experience of policy implementation. It seemed similar to the distinction drawn by Beresford and Croft (1993) between consumerist and democratic models of participation.

The conviction that there would be little local interest and the impact would be insignificant was reinforced by discussions between councillors and officers. It appeared to be a 'self fulfilling prophecy', implying that there was no need to make a major resource commitment to either promoting the scheme or to funding a support service. A poorly funded scheme would not have enough resources to generate demand or the capacity to support large numbers of people.

When the local election of May 2000 returned a 'hung council' in Fletcherford, the director of social services predicted that inexperience and lack of policies in the ruling coalition would mean that the real decision making power would pass to senior officers. This seems to have heralded the end of the influence of 'party politics' on policy development for a while and removed the potential for either obstruction or strong support at the political level in the implementation of direct payments.

The user representative supported community -care for disabled people as an 'idealistically correct' policy. However he believed that its potential had not been achieved during the Major administration because that government's aim to reduce spending through public services had meant implementation was inadequately funded. In his view the distinction between health and social care was a social construct, used by Conservative governments to legitimate cuts in public spending. His support for the extension of direct payments as a New Labour policy initiative however was unequivocal.

5.3.5. Room at the bottom? Central Government's approach

The Blair government gave direct payments its increasingly firm endorsement, from the first promise to extend eligibility and take up in the White Paper (Dept of Health 1998a) to the introduction of compulsion in the 2001 Health and Social Care Act. The government's initial support seems to have been influenced by the lobbying of the disability rights movement and complaints about the weaknesses of the community care system. So to that extent New Labour was responding to 'bottom up' pressures for policy change that complemented its own 'third way' objectives for social care. At the national level the policy therefore was developed incrementally with direct payment schemes gradually spreading into traditional Labour strongholds as the government seemed determined to overcome the lingering resistance in some authorities.

The minister explained this approach in interview :

'The gradual evolution and extension of the scheme was partly driven by a sense of slow progress in implementation. We wanted to try and signal, in the way that governments do, that we desired change ... we have got it in the social services performance assessment framework, with a clear emphasis on numbers and the proportion of people getting direct payments. We chose the legislative route as one of the ways that governments signal the priority and importance that we attach to a particular policy. We have changed the basis of the scheme to get what we wanted ... from a permissive to a mandatory scheme.' (John Hutton,, June 2002)

Despite the influence of disabled people no attempt was made by government to make direct payments a universal, rights- based provision. The principle of selectivity through local authority decision-making remained:

'There is a problem that we can only do so much with legislation.... what we did not want to do was substitute our judgement for those of local social services departments. The legislation sets the overall framework and individual councils necessarily have to make the decisions in individual cases. We want to tip the balance as far as we can in favour of the individual who is making the application. But the decision in individual cases needs to be taken by the people on the ground, and I think that is right, there is no other system that can work.' (John Hutton, June 2002)

The co-director of NCIL recognised that this approach from central government presented problems for those struggling with implementation issues at the fieldwork level. Some of this

struggle was because of prevarication and conflict between those with policy and decision-making authority and some because of the distance between those with power locally and those with knowledge of users' needs and preferences.

'The government wants local grass roots action and practitioners are asking for clearer guidance.' [Interview, June 2001]

5.4. Concluding Discussion

The Conservative government gave local authorities the power to make direct payments within their statutory duties in implementing community care policy (1990 National Health Service and Community Care Act). Those duties in turn were a legacy of the 1948 National Assistance Act which, in repealing the Poor Law, placed publicly funded social care within a selective/ residual model of welfare and outside of the provision of the universal rights- based health service. The New Labour government decided to adopt and promote direct payments within this policy legacy. Councils were left with responsibilities for rationing resources and resolving capacity issues despite the governments concern with 'fairness' (Dept. of Health 1998a, 2.25). The problem of distinguishing the health and social care elements of the services needed by disabled people was left to be resolved during implementation, despite the government's wider policy objectives of ensuring that users experienced seamless services (Dept of Health, 1998a, 6.3). The minister's explanation of the government's approach to securing implementation was framed within an individualist model of direct payments. There seems to have been no consideration of an alternative collective model with the introduction and management of direct payment schemes by users, although this was how some of the earlier schemes had developed, and achieved the successful outcomes that led to 1996 Act (Zarb and Nadash, 1994).

The literature suggests that there is potential for policy making to continue during the implementation process and that the efforts of policy makers may have unintended effects. This is particularly the case where: discretionary powers are given by one tier of government to another (Hill 1981): where they are not administered by 'committed' agencies (Meier and Mc Farlane 1996) and where discretion in decision making is exercised by practitioners in interaction with citizens (Lipsky 1980, Hudson 1989, Wells 1997). Policy initiatives that are not integrated within a coherent programme, without precise goals, without clear implementation rules, are less likely to have their intended impact (Meier and Mc Farlane 1996).

New Labour's guidance on extending direct payments and their inclusion in performance monitoring mechanisms obliged local authorities to show willing in their approach to this initiative. However lack of prescriptive direction left local councils considerable discretion in the design of local schemes over the next two years. It appeared that in drafting the guidance the

government intended to leave the potential for policy to continue to be made through decisions made in implementation at the local level.

Chapters one, two and three outlined the historical, political and philosophical context for the development of central government policy on direct payments as an initiative embedded within the development of community care policy. This chapter has begun the case study of policy implementation, by considering the interactions between and the cumulative impact of policy interventions in the *historical context* of community care implementation in Fletcherford. Three elements of the 'policy-action process' as distinguished by Barret and Fudge (1981,7) have been explored : *the environmental system* from which policy demand arises, which in this case was the disabled peoples' rights movement at the national level and the local community, formal and informal interest groups and users of community care services; *the political system* in which decisions are made, the New Labour Government and a Labour controlled council; and *the organisational system* through which policy is mediated and executed: the Department of Health, the Social Services Inspectorate, the local authority and social services department and independent sector organisations under contract to the council. The following three chapters will continue to explore these factors in the context of the implementation of direct payments.

CHAPTER SIX

Practitioners : Opinions and Expectations of Direct Payments in 2000

'The implementation process is influenced by professionals and managers as social actors making sense of the changing policy environment and learning to navigate the tensions between centralisation and decentralisation, empowerment and control'
Newman (2001, 99)

6.0 Introduction

The results of a survey of Fletcherford practitioners' views carried out in 2000, early in the planning phase of the implementation of direct payments, are presented next. The practitioners were care managers, whose roles were primarily to assess need and arrange care packages, or direct care providers. The introduction of direct payments implied extra responsibilities for care managers and new areas of discretion in judgement and decision-making. In contrast care providers' roles and responsibilities as employees of the major provider of social care (the council) had been undermined by competition from the independent sector. Direct payments threatened to reduce further both the demand for their services and the control and discretion they exercised in their work.

Most practitioners were initially positive about proposals to introduce direct payments, irrespective of the impact on their personal and group interests. However they were concerned that the potential benefits for local people would be limited by the implementation of the initiative within the context of community care arrangements and resource limitations. Practitioners generally supported the policy objectives of Blair's government.

Practitioners explored the validity of social policy theories within the context of their own experience of community care implementation, through the stimulus of a series of statements. The relevance and implications of the literature to their accounts is considered in the final discussion.

6.1 Sample

Care Managers :

I contacted all thirty-six practitioners from six care management teams and interviewed thirty-two.

Care Providers:

I interviewed 30 practitioners from day, domiciliary and community support services (the range of the council's social care provision). Practitioners from each of the client specialisms participated. Because of the large numbers of staff involved and the practical difficulties taking time out of work for interview, the response rate was lower for providers.



Table 6.1 Response Rate

	Total Care Managers	Care managers Interviewed	Total Care providers	Care providers Interviewed
Older and disabled people	19	16 (85%)	90	18 (20%)
Generic	1	1 (100%)	0	0
Learning disability	8	7 (88%)	30	6 (20%)
Mental health	8	8 (100%)	18	6 (33.3%)
	36	32 (90%)	138	30 (22%)

6.2 Where 'Purchasers' and 'Providers' agreed

Practitioners were presented with opinion statements drawn from the literature, reports of the 1997 consultation and the views expressed by senior managers in initial discussions about direct payments. Their responses are shown below, together with selected illustrative comments. Differences between the two groups from the expected frequencies were tested using the Chi-square test. In this section any apparent differences were not significant at the 5% level of probability and are therefore not reported.

Table 6.2

1. *'Direct payments are about giving people money and leaving them to get on with it'*

	Care Manager	Care Provider	Total
Agree	3	3	6 (9.5%)
Don't know	2	0	2 (3.5%)
Disagree	27	27	54 (87%)

The majority disagreed, commenting that users should be offered support and information :

'You've got to give them advice to be fully informed... with a new system people have to learn how to use it' CM19

'It is about giving people control over their lives, but putting support in if that is needed' CP10

Six people agreed.

Table 6.3

2. *'Direct payments are about giving users control over the services they get'*

	Care Manager	Care Provider	Total
Agree	31	28	59 (95%)
Disagree	1	2	3 (5%)

Those who agreed had alternative interpretations of what 'control' might mean for service users:

'Because services are limited by lack of market competition, it is difficult to give control when we have so few [good providers] who work in an enabling way.' CP10

'A lot of people go to bed when home care can fit them into the schedule, they might not want to go at seven o'clock at night.' CP20

One saw user control as an opportunity for personal development

'Agree, it would give them more confidence.' CM31

Three people disagreed, suggesting that direct payments would extend choices but not really give users control.

'... you can not say that they have got control over the whole service, just some control over their own package, some choice.' CP9

'Control over what they pay for, times, days control over their care package, but not over the services...' CP24

Table 6.4

3. 'Direct payments are about enabling users to become employers'

	Care Manager	Care Provider	Total
Agree	22	23	45 (72.5%)
Don't know	4	1	5 (8%)
Disagree	6	6	12 (19.5%)

Practitioners who disagreed said that users should have the option of buying services from independent sector organisations, to exercise purchasing power and choice, without the responsibility and additional stress of being employers. One suggested that users with purchasing power might stimulate the development of the social care market, with the opportunities and risks implied:

'It may not be staff, it may be something else. A number of day care places may open up.... but they may go out of business and leave people with no service, that is a worry.'
CM 29

Table 6.5

4. 'Direct payments are about turning clients into consumers'

	Care Manager	Care Provider	Total
Agree	17	23	40 (65%)
Don't know	1	0	1 (1.5%)
Disagree	14	7	21 (34%)

Most who agreed regarded the initiative as an extension of the move to consumerism in community care policy:

'I've mixed feelings about the ethos of the market place, it was devalued by Thatcherism. But anything, which gives dis-empowered people more control, I would be in favour of, even if called 'consumerism.' CM 27

Some disagreed:

'They are more to do with freeing a person, giving a disabled person a chance to live their life in a normal way, whatever "normal" is.' CP11

Others commented that a care relationship should not be commodified:

'That sounds as if they are buying you, a care worker. I do not like the sound of that, as if a person is for sale.' CP16

5. 'I have known people who would have benefited from direct payments'

Although eight practitioners said that they had not known anyone who would have benefited from direct payments, only four said that they expected that hardly any users would benefit from direct payments.

6. 'People here won't be interested in direct payments'

The vast majority of practitioners (56 or 90%), disagreed with this statement. In contrast, the opinion expressed at the time by senior managers, professional advisers and politicians was that there would not be much interest in direct payments from local people. However they had been encouraged to expect a low take up (see chapter V):

'The more people are educated about what direct payments entail, the more likely they are to use them. Once someone does it and it is successful it will have a snowball effect.' CP11

'Disagree, provided it's promoted and done properly... Workers should be going out and selling it to individuals.' CM15

Two who agreed said that was based on their experience with older people only.

Table 6.6

7. 'Direct payments will probably be best for younger people'

	Care Manager	Care Provider	Total
Agree	<u>7</u>	<u>9</u>	16 (26%)
Don't know	<u>2</u>	<u>0</u>	2 (3.5%)
Disagree	<u>23</u>	<u>21</u>	44 (71%)

This statement reflected views expressed by managers of services for older people, as well as the 1997 Consultation Report.

Some practitioners, who agreed, explained that many older people lived alone and were too frail to manage direct payments without family help. They were also said to fear change:

'With the council's home care, you get a service user who has had someone for five years and they do not want to change. I had one crying today because she does not want to upset me. She said she likes me, but she would rather have her usual worker.' CP26

However most practitioners disagreed. They said that older people had vast knowledge and experience to draw on in managing care arrangements and would be particularly adept at getting value for money:

'I can think of some older people that are quite capable, still going on with their lives and looking to try new things.' CP 19

Table 6.7

8. *'Direct payments are for people who are dissatisfied with the services we offer'*

	Care Manager	Care Provider	Total
Agree	3	8	11 (18%)
Don't know	3	0	3 (5%)
Disagree	26	22	48 (78%)

Most practitioners preferred to explain users' desire for direct payments in a more positive way. Users would want to be able to arrange their own care to suit their personal preferences and circumstances:

'People can be satisfied but still want to take control. A greater degree of self-determination and more choice.' CM 27

'Some people do not use services because of the stigma.' CP18

Some agreed :

'Maybe they think it is a way that they can get what they want, which is right they should have what they want, but it is not that easy to arrange.' CP 20

Table 6.8

9. *'Direct payments should be about people getting together to run their own services'*

	Care Manager	Care Provider	Total
Agree	17	13	30 (49%)
Don't know	4	0	4 (6.5%)
Disagree	11	17	28 (45.5%)

Almost half agreed, but usually qualified their response with the comment that this would be the 'ideal' and not necessary for successful outcomes for everyone:

'Yes in an ideal world, but some people could fall through the net, not be part of the group.' CM19

Slightly fewer disagreed, some of whom talked about the practical problems of disabled people 'getting together':

'I can see it for a small group but not for most people. Older people who are housebound, people who are isolated from each other, only see us and their families.' CP19

Others stressed the 'individualist' aspect:

'They are about accessing the services the person feels are appropriate and having control, individual choice.' CM9

'You would cause World War 3. Most regard finances as very private and it's a personal matter to most of them, the care they get.' CP 28

'I can not see older people discussing private things. They do not like other people knowing their business.' CP 29

Table 6.9

10. 'Service users might use direct payments for the wrong things'

	Care Manager	Care Provider	Total
Agree	24	19	43 (70%)
Disagree	8	11	19 (30%)

Senior staff involved in planning the introduction of direct payments raised this issue. The majority of practitioners who agreed usually said that it applied to very few people:

'There is always a risk with a minority' CP19

For most practitioners, this risk did not dampen their enthusiasm for the initiative. They suggested that support would help people to use their payments effectively. They also stressed that community care users were no less responsible than any other section of society.

Those who disagreed generally commented that direct payments were intended to allow users to make choices and prioritise. One asked :

'Who decides what's the wrong thing?' CM22

Community care eligibility criteria had removed housework from the list of domiciliary services the council provided. The home care practitioners generally agreed that many people would prefer to have their homes clean and tidy than be bathed or cooked a meal. One suggested:

'Clean windows are as good as anti-depressants for anyone stuck in the house all day.'
CP21

Table 6.10

11. 'Direct payments are a threat to in-house services'

	Care Manager	Care Provider	Total
Agree	13	13	26 (42%)
Don't know	3	0	3 (5%)
Disagree	16	17	33 (53%)

Just over half disagreed, often commenting that council services had been under threat since the early implementation of community care policy and the introduction of price based competition. In-house provision had been rationalised to such an extent that demand exceeded supply, irrespective of alternatives:

'Most people would rather have us [home care] but we are not taking on new cases.'

CP19

Although it was the 'care providers' whose jobs were potentially threatened by competition, they were not more inclined to agree with this statement than care managers.

Most who agreed commented that concerns about the future of in house services should not influence decision-making in the implementation of initiatives that would improve the lives of service users and the flexibility of their care arrangements:

'We are restricted in what we can do. If our users hear that on direct payments they can direct what care staff do they may go over.' CP21

'Users are happy with home care but we can not be flexible.' CP 22

However four people commented that direct payments were the latest stage in a process of privatisation of social care and undermining public services.

'We are losing our jobs anyway. With girls¹⁷ relying on wages for paying mortgages, we are bound to see it as a threat.' CP27

Table 6.11

12. 'People who get direct payments will probably use agencies'

	Care Manager	Care Provider	Total
Agree	14	11	25 (40%)
Don't know	4	0	4 (6.5%)
Disagree	11	19	30 (48%)

A significant minority of practitioners said that some users would choose to use domiciliary agencies so that they could organise their care arrangements without too much extra responsibility. Also users may want to use agencies in emergencies. Almost half disagreed, predicting that users would prefer to pay someone of their own choice for care rather than use agencies:

'The opposite, they will get the money to avoid using the agencies.' CP30

Practitioners suggested that users might chose to recruit staff they knew to secure the consistency in personnel that agencies do not offer:

'If they do not get the choice to use our home care, they will either go to friends or ask someone they have had through an agency to work for them directly.' CP28

'I do not think they would use agencies if they had the choice. They might ask one of our girls or an agency girl, someone they trusted.' CP29

13. 'Most people will need a lot of support if they are going to get direct payments'

Most (89%) agreed and usually commented that users will probably need help when they first receive direct payments:

'Initially but not long term, it's not rocket science.' CM15

¹⁷ Home care practitioners referred to themselves and workers in similar roles in the independent sector as 'girls', although all the people I interviewed had between ten and thirty years service. Most drew on years of unwaged experience of caring for children and elderly relatives.

Those who disagreed all said that the need for support would vary between individuals and that many would manage unaided.

Table 6.12

14. *'Direct payments could mean a lot of work for social workers'*

	Care Manager	Care Provider	Total
Agree	13	18	31 (50%)
Don't know	4	0	4 (6.5%)
Disagree	15	12	27 (43.5%)

Whether or not practitioners agreed with this statement, the general comments were to the effect that the impact on the workload of social workers was irrelevant. They must adapt to change and implement policy initiatives in the course of their work:

'Jobs change all the time. We all have to change.' CP20

Table 6.13

15. *'There's a risk that people will be exploited if they are given the money to buy their own care'*

	Care Manager	Care Provider	Total
Agree	26	22	48 (77%)
Disagree	6	8	14 (23%)

The majority agreed, irrespective of client specialism. Some practitioners commented that direct service users were sometimes exploited and the risks would not increase with direct payments:

'Agree, but it is up to the local authority to make sure it does not happen. They are already being exploited by the system.' CM15

'Disagree, there will be no more risk than there is at the moment.' CM14

Some of those who disagreed said that users would be less vulnerable to exploitation if they were in control of their care packages and budgets.

Table 6.14

16. *'If our services were good enough people would not want direct payments'*

	Care Manager	Care Provider	Total
Agree	8	6	14 (22.5%)
Don't know	2	0	2 (3.5%)
Disagree	22	24	46 (74%)

Most were keen to stress that however 'good' services are, some individuals would prefer to manage their own care. Lack of flexibility and responsiveness to the wide range of needs were mentioned as more relevant:

'Good enough is not it. We have got good services. What we have not got is the flexibility and the funding to support people with complex needs who want to live in the community. We have a very lean and mean 'spread thinly' culture, that works for some.' CM25

17. 'People should be able to use direct payments for more than just personal care'

The power to make choices according to personal preferences was perceived as a major advantage for almost all the practitioners (95%). They considered that people have 'social needs' as important to their well being as the need for personal care. However rationing measures implemented with community care policy meant that social needs were often not addressed, particularly with older people:

Practitioners working with older people, however, were just as likely to agree with this statement and to recognise the importance of social needs:

'Agree, anything that benefits their well-being, within reason.' CP19

Only two people disagreed.

Table 6.15

18. 'People already have a lot of choice over services here'

	Care Manager	Care Provider	Total
Agree	10	11	21 (33.5%)
Don't know	2	0	2 (3.5%)
Disagree	20	19	39 (63%)

Most disagreed:

'On paper it looks good when you see all the agencies, but the private sector are generally rubbish.... They are not getting a choice when they are sent to the private sector instead of social services home care.' CP19

However the third who agreed said that they were aware that there were a number of independent providers in the community care market locally, but they also expressed concern about the quality of services:

'There are quite a few agencies, but there is a need for "decent" care. Two are specialist agencies. Cheaper agencies provide poorer services.' CM1

Table 6.16

19. 'People should be allowed to use direct payments to buy community health services'

	Care Manager	Care Provider	Total
Agree	12	12	24 (38.5%)
Don't know	4	0	4 (6.5%)
Disagree	16	18	34 (55%)

Although statements that advocated that users should be able to choose how to spend their direct payment usually elicited agreement, over half argued that health is different. Disagreement was based on principles of social justice and the collective values of a taxation funded, rights based system. Money seemed to be perceived as a potentially negative influence in health care delivery rather than a source of empowerment:

'Health care should be free at the point of contact, money is used to jump queues, money gives choices.' CM2

'Not if it is the NHS, patients have paid into that' CP3

'The health authority have a duty to provide health care.' CM 24

'When it comes to health care, money should not change hands.' CP17

One practitioner defended the NHS as the last bastion of the welfare state:

'Keep the health service separate. Do not start privatising that or there will be nothing left.' CP27

Only one suggested that clinical judgement and professional expertise were more important than personal preference in health care.

Over a third agreed, usually saying that direct payments for health care would be consistent with the policy trend towards integration and that users would be able to overcome problems of fragmentation in packages delivered by separate agencies:

'We work in partnership now, health and social care should come as a package if needed.' CM25

Table 6.17

20. 'There's not enough money to pay for all the services that people want, direct payments mean users must decide what to do without.'

	Care Manager	Care Provider	Total
Agree	20	18	38 (61.5%)
Don't know	4	0	4 (6.5%)
Disagree	8	12	20 (32%)

Most agreed but usually said that given that resources are limited, users should be allowed to decide their own priorities:

'To say users must decide what to do without is putting it in a negative way. It should be, service users deciding what they need most. None of us can have exactly what we want.' CM4

'In one way [the council] are "passing the buck" but it might be a good thing for users to take responsibility.' CP2

'It would help them to prioritise what is most important to them' CM11

Not all who agreed foresaw any advantage for users:

'It is going to help them understand where we are coming from, but it is not necessarily going to help them.' CM28

Almost a third disagreed, some argued that resources could be used more cost effectively by users themselves.

'It is a question of managing resources and encouraging natural supports and community involvement, which are free. Inclusion is free. You need initial input to build networks, short term input for huge savings in the long term.' CM15

'They should not have to do without. Users could shop around and get a better deal with support.' CM32

21. 'Direct payments will only work for people who do not need a lot of care'

Only three people agreed with this statement:

'It is choice, whether they get a lot or a little care. More care, more money, more choice.' CP24

Table 6.18

22. Direct payments could have a big impact on community care here in the future.

	Care Manager	Care Provider	Total
Agree	21	22	43 (70%)
Don't know	4	0	4 (6%)
Disagree	7	8	15 (24%)

Most responded optimistically: *'Hopefully for the better'* CM9

However one person who agreed with this statement did not foresee the introduction of direct payments as having a positive outcome for services users:

'On business, they will generate entrepreneurial growth. Where there is money there is growth and greed. We are already in conflict with agencies touting for business and encouraging people to drop our services.' CM20

Most of those who disagreed explained that they nevertheless expected that direct payments would create an extra option that could have a big impact on some individuals' lives.

Table 6.19

23. 'We are only talking about introducing direct payments here because the government says we must.'

	Care Manager	Care Provider	Total
Agree	17	16	33 (53%)
Don't know	5	0	5 (8%)
Disagree	10	14	24 (39%)

Despite the general support for direct payments, more than half the practitioners were not convinced that their employers would be implementing the initiative without top-down pressure from government:

'Probably a bit of that and a bit of trying to get what is best for everybody.' CM12

One less enthusiastic practitioner interpreted this statement as a way of attributing blame rather than credit:

'This has come from the government. Tony Blair has a lot to answer for. As far as I am concerned he is just another Tory.' CP27

Those who disagreed usually explained that the introduction of direct payments was consistent with the council's own 'modernising' agenda:

'We have been very pioneering in lots of ways. I think we have not done it until now because of lack of demand and lack of information.' CP13

Table 6.20

24. *'People here are generally happy with the services on offer'*

	Care manager	Care provider	Total
Agree	22	25	47 (76%)
Don't know	1		1 (1.5%)
Disagree	9	5	14 (22.5%)

The majority agreed but suggested that it should not be assumed that users' satisfaction meant services were good:

'People here generally have low expectations, they are generally happy with services. You only tend to get objections when you change something.' CM14

'Agree, but they have not got a choice. If we were offering direct payments, then you would see. But at the moment they have only one choice.' CM17

Those who disagreed talked about unmet needs and peoples' experiences of using independent sector provision:

'Disagree, from my experience there are gaps in the care offered.' CM27

'They are happy with social services and home care but not the private agencies. They put up with them because there is no choice.' CP 19

6.3. Where 'purchasers' and 'providers' differed

Only nine of the statements provoked a statistically significant difference in the responses of practitioners with 'purchasing' or 'providing' roles.

Table 6.21

25. *'Direct Payments have come from a policy of the last Conservative government'*

	Care Manager	Care Provider	Total
Agree	16 (50%)	9 (30%)	25 (40%)
Don't know	12 (38%)	1 (3%)	13 (21%)
Disagree	4 (12.5%)	20 (66%)	24 (39%)
Chi square test	$X^2 = 21.9$	$P < 0.001$	

Half the care managers felt that direct payments had come from a Conservative government policy, whereas two thirds of the care providers did not. Although practitioners suggested that consumerism and the social care market originated in Conservative government policies, most care providers who supported direct payments were reluctant to give any party credit for the initiative:

'I think it would have happened irrespective of who was in government. Progress and pressure groups would have brought it about.' CP 10

'... but direct payments are something that evolved, it makes no difference who made the policy.' CP11

'I think disabled people would have asked for it whatever government it was.' CP12

Practitioners who had reservations about direct payments were more inclined to explain their origins in party political or ideological terms:

'They were probably brought in with privatisation in mind. One of the users said three years ago that it was a way of closing down the day centre and getting rid of jobs.' CP17

Table 6.22

26. *'Direct payments are not very different from other schemes that have been around for years.'*

	Care Manager	Care Provider	Total
Agree	16 (50%)	6 (20%)	22 (35%)
Don't know	1 (1.5%)	1 (1.5%)	2 (3.5%)
Disagree	15 (48%)	23 (76%)	38 (62%)
Chi square test	$X^2=6.2$	$P<0.05$	

Care providers were more likely than care managers to perceive direct payments as a departure from established ways of arranging community care services. However one care provider recounted how her mother's generation was providing care and support to elderly and disabled neighbours, before community care policy was developed:

'Direct payments are not a new thing, they are an old thing brought back.' CP19

Over half the care managers but less than a quarter of the care providers had experience of the Independent Living Fund. This may account for half the care managers agreeing.

Table 6.23

27. *'Many service users would worry about the responsibility of getting a direct payment'*

	Care Manager	Care Provider	Total
Agree	20 (63%)	27 (90%)	47 (76%)
Don't know	1 (1.5%)	0	1 (1.5%)
Disagree	11 (34%)	3 (10%)	14 (22.5%)
Chi square test	$X^2 = 6.5$	$P < 0.05$	

The vast majority of providers agreed :

'Yes, until they have tried it. But as long as they know they can go back [to direct services] they may have a go.' CP20

A third of the care managers disagreed:

'Most of mine would love it.' CM 31

'Not if it is done properly, being supported. Loads of service users would be able to manage fine.' CM32

Client specialism was not significant in the analysis of whether practitioners agreed with this statement.

Table 6.24

28. *'Third party schemes employing personal assistants on behalf of users would do the same as direct payments'*

	Care Manager	Care Provider	Total
Agree	4 (12.5%)	12 (40%)	16 (26%)
Don't know	9 (28%)	0	9 (4%)
Disagree	19 (30.5%)	18 (60%)	37 (60%)
Chi square test	$X^2 = 13.0$	$P < 0.01$	

Most practitioners disagreed, but the idea of third party schemes was clearly more acceptable to providers than care managers, possibly because more of them felt that service users would worry about the responsibility of getting a direct payment:

'Some people would need the third party for guidance and to have control, that is with support and relief of responsibility they would be more able to exercise control.' CP19

Nevertheless most care providers also disagreed:

'The difference is you can not be in control. You can not just change things to suit yourself. Direct payments are negotiable on a one- to- one basis between user and worker directly.' CP11

'I would think that is just like social services doing it. I would not agree that it is safer for the person for a third party to be involved.' CP12

Again client specialism was not significant in the responses to the statement that 'third party schemes' would do the same as direct payments. In particular practitioners working with people with learning disabilities did not support this view more than other staff. However the government's proposal to introduce 'indirect payments' (Dept of Health 2002) is intended to extend the 'take up' by people with learning disabilities.

Table 6.25

29. *'People should get direct payments through the normal assessment processes'*

	Care Manager	Care Provider	Total
Agree	23 (72%)	16 (53%)	39 (63%)
Don't know	4 (12.5%)	0	4 (6%)
Disagree	5 (15.5%)	14 (47%)	19 (31%)
Chi square test	$X^2 = 9.5$	$P < 0.01$	

Care providers had less confidence than care managers in established assessment processes. Those who were critical of care management assessments said that they tended to overestimate users' needs and to offer more care than users wanted or could cope with:

'It depends on the social worker too much. We get referrals that paint picture of people with needs so great we think "this is not the same person". The social worker goes in during a crisis, once that is over it is a different picture.' CP15

'They are assessed for the wrong things. A service user will sit there and just say yes to what the social worker says. A lady was assessed as needing personal care and breakfast. When I got there she was dressed and fed and wanted me to Hoover and go shopping.' CP21

'A lot of cases we go and see for ourselves and think "What are we doing here". They say "I don't need that, I only wanted the windows doing"..' CP22

One day centre worker explained how individuals' needs are influenced by their social situation and emotional state:

'There are people who come here and the referral says that they can not do this or that and we think "They must have been having a bad day when they were assessed.". But what can the social worker do? Sometimes this place is like Lourdes, they rise up out of their wheelchairs at the Christmas party.' CP20

Another suggested that care managers can manipulate eligibility criteria to get funding to meet an individual's preferences, rather than just basic needs, if they know the person well enough:

'Assessments are going to have to be really in depth, based on a relationship, not a one-off visit. As they stand at the moment they are not enough. But people should be able to apply for direct payments without a re-assessment. It makes social workers gatekeepers again, but they can channel wants through needs.' CP10

Care providers also commented that care management assessments of older people and people with physical impairments were based on very limited contact with the person, possibly in crisis, whereas their own knowledge of user needs and family circumstances was based on a longer term relationship. One provider however was concerned that additional assessments could be used as a way of obstructing access to direct payments:

'We should not make people jump through too many hoops' CP14

Care managers were generally concerned that people who requested direct payments should not be subject to a more rigorous assessment process than those willing to accept direct services. Four care managers said that, without experience of enabling users to access direct payments, they did not know whether established processes would be appropriate. Five said that they felt a more thorough assessment would be demanded because of the capacity and consent issues. Most care managers maintained that current assessments were already based on users' own views:

'Assessments are based on what the care manager is told by users and carers. If the information needs to be double-checked, it is a time consuming process.' CM24

Some care providers agreed:

'People can tell the social worker what they want. Some exaggerate and others will not acknowledge their needs.' CP17

In contrast one care manager expressed concern that the use of established assessment processes would undermine the empowering potential of direct payments:

'It is back to the power thing. If we decide, it is another corporate tool. It is supposed to be for people to have more control over their lives.' CM15

Another was concerned that current assessments were more concerned with eligibility and availability of resources rather than need :

'Are they going to be finance led as with current assessments? Is need going to be assessed regardless of benefits or capital? Are direct payments for everybody or will they discriminate against people with savings?' CM 19

In the semi- structured part of the interview, care managers acknowledged that they sometimes over estimated users' needs (and therefore resource requirements). They did not do this because they were over protective of their clients or themselves (although 'risk aversion' was an issue discussed in other contexts). They explained that in the competition for scarce resources, they were more likely to secure the necessary budget allocation if they asked for more than was required.

Table 6.26

30. *'There are other ways of empowering users without giving them cash'*

	Care Manager	Care Provider	Total
Agree	25 (78%)	16 (53%)	41 (66%)
Don't know	2 (7%)	0	2 (3%)
Disagree	5 (15%)	14 (47%)	19 (31%)
Chi square test	$\chi^2=8.2$	$P<0.05$	

Almost half the care providers, but only 15% of care managers, considered that giving users the control over their own care budgets was more empowering than alternatives.

A majority overall could identify effective alternatives based on involving users in decision-making processes.

'We are trying to empower users all the time within the care packages. That is what the job is all about...' CM 31

'It does not have to be about cash. It is about not being restricted and not being stuck with what you are not happy with. Cash is one way.' CP23

Nevertheless they did not always express confidence in the alternatives:

'Yes but in a materialistic cash oriented world, there is a lot of power in having pounds in you pocket. It may make the user feel enabled to say "I am paying for this" ...' CM7

'There are, but for them to be totally empowered they need to be choosing who provides their services. They become employers rather than having the stigma of social services providing for them.' CM 24

'If they had the cash they would feel more in charge, better for their self esteem.' CP 25

Some practitioners suggested that some users are more assertive and therefore get more say than others:

'You can give choice without money. People who are meek and timid, and do not shout, do not get.' CP22

One care provider who agreed had reservations about the 'empowering' potential of choice:

'If they shout loud enough and threaten to go to the papers they get what they want. Sometimes they can be given too much choice; it can be confusing rather than empowering.' CP21

One provider suggested that direct payments could be used to counter the negative impact of unsatisfactory services. She elaborated on the disempowering effects of the experience of poor quality, unreliable private sector domiciliary services:

'It is not the cash as such. It is choice, trust, continuity and reliability that are more important and that give the person confidence. It is little things like someone coming in wearing an overall so they know who they are. In the private sector they wear jeans and T shirts.... Knowing what to expect makes people feel less powerless than when they do not know what is happening or who is turning up next. If money gives them control then great, but they should not have to get a direct payment to feel safe and confident that their needs will be met. They are afraid of change because they are used to things getting worse not better. Trust is important and some of that has been lost.' CP 28

Table 6.27

31. *'If I needed community care services I would want a direct payment'*

	Care Manager	Care Provider	Total
Agree	26 (82%)	30 (100%)	56 (90%)
Don't know	2 (6.5%)	0	2 (3.5%)
Disagree	4 (12.5%)	0	4 (6.5%)
Chi square test	$\chi^2 = 6.2$	$P < 0.05$	

All the providers were confident that they could make more satisfactory arrangements for themselves than direct services would offer:

'I would want to be in control, to do what I need or want to do, at the time I want to do it. Being in bed waiting for someone to get you up must be horrendous.' CP10

'It is about the control aspect. Being better informed, having power to feel people responded to what I needed rather than what other people required of them. Holding cash would be important, because of the ability to change rapidly if dis-satisfied and avoid long [bureaucratic] processes.' CP 4

'Now, knowing what I do, I would choose to pick my own [personal assistant] and employ her....' CP 29

However four of the care managers said that they would prefer not to have the responsibility of organising their own care. Two others said that it would depend on the nature of their needs.

Table 6.28

32. It is difficult to get good care staff here'

	Care Manager	Care Provider	Total
Agree	19 (60%)	10 (33.3%)	29 (47%)
Don't know	5 (15%)	0	5 (8%)
Disagree	8 (25%)	20 (66.7%)	28 (45%)
Chi square test	$X^2 = 12.4$	$P < 0.01$.

Care managers were quicker to identify recruitment and retention problems in the labour market for care staff:

'Agencies seem to have problems recruiting experienced staff, probably because they pay the minimum wage.' CM1

'They wander from agency to agency. If they get one awkward customer they think "I'm not putting up with this" and go on to another one. They all pay the same low rate. The specialist agencies tend to keep their staff. They pay more but they charge more, but provide excellent services.' CM 26

Care providers did not criticise other care workers. They commented on the problems of poor pay and conditions and lack of training and support in the independent sector:

'Agency staff have to pay for their own training, ours do NVQs... We try to keep our staff local so they know the patch and the people. They get sent from one end of town to another.' CP24

Both care managers and providers commented that users may be able to recruit people from their own communities willing to care for a known individual, but not to work for an organisation:

'There are a lot of caring people but not necessarily with the qualifications organisations seem to require now.' CP 9

'Direct payments come into their own, employing someone who gives care rather than a care worker.' CM14

'It may not be difficult to get caring people who do not have to sign up to our policies and procedures. Our staff feel very restricted by the parameters they have to work within.' CP 14

Only one practitioner (a man) mentioned gender as a staff recruitment issue, although the overwhelming majority of care staff were 'girls':

'It is difficult particularly to get a male carer. Some users do not mind if it is male or female but a lot of men would prefer a male worker.' CP 17

Table 6.29

33. *'The cash to buy their own care is what users have wanted for years'*

	Care Manager	Care Provider	Total
Agree	5 (15%)	3 (10%)	8 (13%)
Don't know	6 (19%)	0	6 (9%)
Disagree	21 (66%)	27 (90%)	48 (78%)
Chi square test	$X^2 = 7.2$	$P < 0.05$	

The majority disagreed but providers did so more frequently. The comments commonly made were to the effect that local users would not have imagined that direct payments could ever be an option and until recently had 'taken for granted' that the local authority would always be the provider of social care:

'They have not known about it or thought about it, social services have always been at the end of a line to sort things out for them.' CP2

'I don't think people have known about direct payments ... we have intentionally or unintentionally kept the information to ourselves.' CM15

One provider recognised that disabled people had campaigned nationally for the introduction of direct payments.

'Not so much in this area but in other areas, down in Hampshire for example' CP1

Differences between client specialisms were not significant.

6.4 Practitioners' Expectations

Practitioners were asked if they could foresee potential benefits for service users in the introduction of direct payments to Fletcherford. The majority (forty six) thought that direct payments would benefit more than a small minority of community care services users. The chi square test of significance found that differences in expectations were not accounted for by different roles in the community care 'market'. Eligibility for direct payments had been limited by government guidance to particular user groups (to give the schemes the chance to show success without being overwhelmed by applicants). Since the relaxation of the 'able and willing test' and the extension to older people in 2000, the take up between different user groups continued to vary nationally. However there were no significant differences between practitioners from different client specialisms in their expectations of user benefits. Practitioners were also asked if they had any worries about the introduction of direct payments. Just over half the practitioners (thirty six) had few or no worries about direct payments and again there was no significance in the differences in the responses between the two groups or between client specialisms. Therefore most practitioners had on balance positive expectations of direct payments, although they did not contemplate the implementation of this initiative without any concerns. Only five people had no worries about direct payments and only four thought that hardly any users would benefit from their introduction.

6.5 Themes from interviews with care managers and care providers

Themes from interviews with care managers and care providers were cross tabulated with roles and tested for significance. In the course of the interviews the following themes emerged.

6.5.1. Outcomes and benefits

Practitioners elaborated on the specific benefits/ outcomes for service users they expected from direct payments. Eleven benefits were identified.

Table 6.30 *Potential Benefits for Users*

Benefits Identified	Care managers	Care Providers	Total identifying this benefit
1.Choices and flexibility	23 (69%)	23 (76.5%)	46 (75%)
2.Control, autonomy, responsibility, freedom	26 (81%)	20 (67%)	46 (75%)
3.Promote independence	9 (28%)	17 (57%)	26 (42.5%)
4.Individually tailored services not based on bureaucratic rules	9 (28%)	11 (37%)	20 (32%)
5.Relationships, consistency and compatibility of staff	4 (12.5%)	13 (44%)	17 (27.5%)
6.Better value, users get more for the money	6 (19%)	11 (37%)	17 (27.5%)
7.Empowerment, rights, citizenship	11 (34%)	5 (17%)	16 (26%)
8.Self esteem, capacity, confidence, dignity	5 (18.5%)	9 (30%)	14 (22.5%)
9.Inclusion, non-stigmatising, normal life	5 (18.5%)	6 (20%)	11 (18%)
10.Joined up services, holistic, meet all needs, no gaps	0	3 (10%)	3 (5%)
11.Collective identification, community development	1 (3%)	2 (6.5%)	3 (5%)

Two kinds of positive outcomes were most commonly identified. They were *choice and flexibility*, benefits associated with ‘consumerist’ approaches and *control, autonomy, responsibility and freedom* associated with New Labour’s ‘third way’ terminology or modernising discourse. The next most commonly identified outcomes, *promoting independence* and *individually tailored services*, could have been taken straight from the White Paper (Dept of Health 1998a) although it was not quoted directly.

The outcome of *relationships with consistent and compatible care staff* was mentioned by seventeen practitioners. As many suggested that users would get better value from scarce resources, an intended outcome described in the policy guidance on direct payments (Dept of Health 2000a), consistent with the rationale of market theory. The ‘third way’ objectives of *empowerment, rights and citizenship* were the next most frequently mentioned. Direct payments were also discussed as a means of enhancing personal development.

A minority identified direct payments as a means to social inclusion for disabled people, although this is a 'third way' objective promoted in relevant policy documents. The New Labour idea of 'joined up' health and social care services occurred to only three practitioners. This could be partially explained by the strong support expressed for a 'collectivist' approach to health care, based on universal rights and principles (above).

Practitioners seemed to perceive the benefits of direct payments, in terms of an 'individualist' model. Similarly only three referred to the benefits of users identifying collectively with each other and the potential stimulus to 'community development'.

6.5.2 Worries

Practitioners discussed their own worries about the implications of the introduction of direct payments. Thirteen themes emerged.

Table 6.31 *Specific Worries*

Worries identified	Care managers	Care providers	Total expressing this worry
1. Poor quality care, inappropriate use of money	14 (43.5%)	17 (57%)	31 (50%)
2. Risks of abuse	16 (50%)	9 (30%)	25 (40%)
3. Threats of the market, profit motive, market weaknesses	9 (28.%)	14 (47%)	23 (37%)
4. Risk of users being exploited	7 (22%)	10 (33%)	17 (27.5%)
5. Extra burden, more responsibilities for users	10 (32%)	6 (20%)	16 (26%)
6. User acquiescence, reluctance to complain	5 (18.5%)	4 (13%)	9 (15%)
7. Inadequate or inappropriate support	2 (6%)	6 (20%)	8 (13%)
8. Worry if support service not local	6 (19%)	1 (3%)	7 (11%)
9. What will happen in emergencies, crises	1 (3%)	5 (17%)	6 (9.5%)
10. Recruitment and retention problems for users	0	3 (10%)	3 (5%)
11. Conditions of services of personal assistants, pay and security	0	3 (10%)	3 (5%)
12. Direct payments may prolong or encourage dependence	3 (9.5%)	0	3 (5%)
13. Isolation of users loss of social contact	0	2 (6.5%)	2 (3.5%)

The most common concern was that the quality of the care might deteriorate if an individual opted out of direct services. This could be explained within a 'care discourse' that understands social care users as incapable of managing their own affairs as effectively as professionals. The second was that direct payments could be abused. While the risks of abuse were frequently mentioned, they were usually qualified by an opinion that they would only be present in a minority of cases.

Dangers associated with the inappropriate application of market principles to the social care situation perturbed some practitioners, suggesting an 'Old Labour' perspective. They expressed the opinion that social care organizations run as 'businesses' would develop, with proprietors primarily motivated by profit rather than the interests of disabled people. The fear was that unscrupulous providers could exploit more vulnerable people, if they were without the protection of local authority contracting arrangements. Some were worried that disabled people and their families would experience managing direct payments as an extra burden of responsibility. The fear that service users' tendency to acquiescence would mean they would accept sub-standard services and abuse without complaint, troubled some practitioners.

Concerns were expressed about the appropriateness of the support service. Nine practitioners worried that it may not be adequately resourced to meet the needs of direct payment users. Eight suggested that only if support were provided by a local organisation would it be 'owned' and trusted by users.

Practitioners were worried about users being left to deal with emergencies without the 'safety net' of social services infrastructure. They also foresaw problems arising for disabled people employing their care staff directly. Three providers were afraid that users would have difficulty recruiting and retaining staff in competition with larger employers. They feared that individuals with very limited purchasing power would be relatively powerless in the community care market. Three providers were also concerned about the pay and security of staff employed by private individuals. Three care managers said they were worried that direct payments could prolong dependency. They suggested that users would be reluctant to reduce the hours of their personal assistants, once they had established a relationship with them, even if their needs reduced.

Two care providers feared that people opting out of congregated day and respite services could become isolated.

6.5.3 Obstacles to Success

Practitioners identified fifteen potential obstacles to the successful spread of direct payments, beyond a small group of pioneering community care service users. There were statistically significant differences between the two groups of practitioners in the responses marked in Table 6.32 (below).

As with the identification of potential benefits and worries shown in Table 6.31 (above), some practitioners foresaw more than one obstacle to expansion.

Table 6.32 *Obstacles*

Obstacles Identified	Care manager	Care Provider	Total
1.Lack of Information and Publicity ¹	20 (63%)	26 (87%)	46 (75%)
2.Uncertainty about implications, lack of clear rules and criteria, unanswered questions.	9 (28%)	14 (47%)	23 (37%)
3.Fear of change	9 (28%)	14 (47%)	23 (37%)
4.Inadequate funding	8 (25%)	6 (20%)	14 (22.5%)
5.Dependency culture, paternalism, trust in public services	10 (31%)	4 (13%)	14 (22.5%)
6.Management resistance, tokenistic response	9 (28%)	5 (17%)	14 (22.5%)
7.Distrust of council's motives, suspicion ²	2 (6%)	9 (30%)	11 (18%)
8.Care manager attitudes ³	10 (31%)	1 (3%)	11 (18%)
9.Charging issues	3 (9.5%)	7 (23%)	10 (16%)
10.Capacity and competency issues	6 (18.5%)	2 (7%)	8 (13%)
11.Work pressures on social services staff	2 (6%)	5 (17%)	7 (11%)
12.Lack of confidence in support available ⁴	5 (15.5%)	0	5 (9.5%)
13.Lack of clear guidance, or lead from Dept of Health ⁵	4 (13%)	0	4 (6.5%)
14.Ideological, fashion, change for its own sake	2 (6%)	2 (7%)	4 (6.5%)
15. Lack of political will, political objections	1 (3%)	2 (7%)	3 (5%)

1. $X^2 = 4.7$ $P < 0.05$

2. $X^2 = 6.0$ $P < 0.05$

3. $X^2 = 8.3$ $P < 0.01$

4. $X^2 = 5.2$ $P < 0.05$

5. $X^2 = 4.0$ $P < 0.05$

Most practitioners suggested that lack of general awareness about direct payments would be the major obstacle to the expansion of direct payments. This was also the reason often given for the lack of 'bottom up' pressure for the introduction of the initiative locally. 'Uncertainty', due to lack of reassuring answers to users' questions and lack of clear procedures for practitioners to follow, was perceived as a potential obstacle. Fear of change was identified and usually related to uncertainty. The local culture in Fletcherford was identified as a potential obstacle to the spread of direct payments. Some practitioners spoke positively about the trust that local people have in public services, others suggested that there was institutionalised paternalism in the relationship between the council and the community.

A minority was cynical about the motives of management in the implementation process, suggesting that responses to 'top down' pressures from government were tokenistic gestures. They suspected that covert resistance to making direct payments an attractive, easily accessible option for disabled people would restrict their expansion beyond a few determined, well-informed individuals. Significantly more providers than purchasers suggested that people would

be reluctant to ask for direct payments because they suspected the motives of the local authority. Care providers claimed that the council had justified the move from congregated day and residential services on the grounds of promoting community integration. However many users and carers had experienced the changes as reductions in the resources available. Another example given for users' mistrust of change was the withdrawal of 'housework' from the range of domiciliary services on offer. Practitioners suggested that direct payments would appear less attractive to users obliged to contribute on a means tested basis because charges were not applied consistently across all types of service. Practitioners acknowledged that they manipulated inconsistencies and used discretion to minimise the charges users paid.

Practitioners speculated that the pressures of work on care managers would limit their opportunities to develop confidence in enabling users to access direct payments. Over-worked staff, might feel stressed by their inability to respond to peoples' needs in a timely and holistic way. They would be reluctant to spend time promoting initiatives that could imply increased demands on their time and knowledge base. More practitioners in purchasing roles said that the attitudes of care managers could obstruct the growth of direct payments. The key role of practitioners as ambassadors for policy initiatives was recognised generally.

It was care managers who predicted that lack of clear guidance and a firm lead from the Department of Health (top down pressure) would mean that those who wanted to subvert the objectives of the government's policy would be able to do so. Three people suggested that lack of strong support from local politicians for direct payments, would mean that other obstacles would be difficult to overcome. Fourteen practitioners predicted that inadequate funding would limit the impact of the initiative.

Four practitioners argued that direct payments would not spread beyond a few experimental subjects because it would become apparent that the initiative has no real value for service users and that it was being promoted for ideological reasons. These two 'purchasers' and two 'providers' had maintained a consistent cynicism about the reasoning behind the introduction of direct payments, and believed that hardly any users would benefit.

6.6. Summary of findings from the survey of practitioners' views in 2000

At the outset, practitioners were generally optimistic about being involved in the introduction of direct payments and about the outcomes for service users. They did not share the reservations expressed by some senior officers but were not unduly idealistic. They recognised the possible problems, but felt that the potential benefits outweighed the risks. The majority expected that there would be a lot of local interest and that direct payments could benefit more than a small

minority of service users. They also foresaw that local people and voluntary groups would have a positive contribution to make to the development and management of a support service.

Practitioners were enthusiastic and keen to co-operate in making a success of the initiative. This was largely irrespective of whether they thought it could have a detrimental effect on them personally, either by threatening their job security or increasing their work- load of responsibilities in implementing policy changes. They were generally critical of the community care policy of the Conservative governments, both in terms of what they perceived as its ideological underpinnings and its impact on public services and those who used them. Most practitioners identified direct payments as a way of users overcoming the negative consequences of the introduction of a market in community care. Only four practitioners did not think that New Labour was motivated at least to some extent by the aspiration of 'empowering' users as consumers, in extending entitlement to direct payments within the mixed economy. They saw New Labour's support for the policy as the Blair government adopting and pursuing the Conservative governments' privatisation objectives. There were practitioners who expressed some cynicism about the motivation and ability of Fletcherford council to implement the initiative effectively. Most identified potential obstacles to the spread of direct payments, which might arise in the planning and implementation processes within the authority. Publicity, clear information and straightforward procedures were seen as crucial to success.

The findings of this survey were circulated within the authority and reported to those responsible for the implementation of direct payments. Planners and decision-makers were thus informed about the views of frontline staff on the potential of direct payments and made aware of the issues identified by practitioners as likely obstacles to their success and expansion.

6.7 Discussion

The initial comparison between the two groups was made to establish whether practitioners' experience and understanding of community care and direct payments varied significantly with their personal and professional interests. This was to establish if there was any evidence, for example, of the 'knavish' behaviour and motivation assumed in contemporary welfare strategies (Le Grand 1997) or to support Tulloch's (1986) 'bureau maximisation' thesis, that public servants will seek to extend their areas of responsibility beyond the limits of efficiency. Practitioners participated believing, as I did, that this was an opportunity to influence the local response to the government's policy on direct payments. They therefore had no reason to disguise their concerns. There was no evidence in their responses and comments that they were motivated by self- interest. However Dunleavy's (1986) 'bureau shaping' theory that predicts senior bureaucrats will pursue privatisation, beyond the limits of cost effective resource use (discussed in chapter one), found support in practitioners' accounts of the local care market. As

in Dunleavy's model, the costs of excessive (in economic terms) privatisation in Fletcherford were borne not by senior bureaucrats but by rank and file workers and service users/ citizens.

Research has shown that social workers have a key role in the implementation of direct payments, informing clients of their 'rights', applying rationing criteria to their 'needs' and assessing their 'suitability' to exercise control over their own care packages and budgets (Bewley 2000, Dawson 2000, Evans and Carmichael 2002). There was no evidence that social workers in Fletcherford in 2000 saw their involvement in the administration of cash for care as a backward step, reminiscent of welfare arrangements before 1948, as Glasby and Littlechild (2002) suggested. Practitioners were aware of official policy objectives and the majority thought that offering users the opportunity to manage their own care arrangements would assist progress towards the achievement of independence, choice and control. Their concerns were whether direct payments would be introduced in Fletcherford in a way that would facilitate the achievement of these objectives. However practitioners' accounts of the effects of the transition from case work to care management confirmed the analysis in the literature (Dominelli 1996, Hudson 2000, Postle 2001). They suggested that implementation of any initiative that was complicated or time-consuming could be problematic within a care management workload.

Practitioners accepted the role of the 'market' in the context of direct payments pragmatically, as a means to the end of improving the care arrangements for individuals, while generally disagreeing with the principles of competition upon which the market reforms in community care were based. Like local politicians, they suggested that users would want to use direct payments to overcome the service deficiencies they attributed to the mixed economy. Practitioners' responses to the statement about resource rationing suggested that users would get better value for money than council purchasers, through behaviour consistent with market theory. This included users as purchasers prioritising the use of available resources to maximise their own utility, attracting new entrants to the social care labour market from their own communities and being able to negotiate for better value, free of the constraints on bureaucratic purchasers of council contracting procedures. Whether or not practitioners believed that community care policy was inherently under-funded, there was general agreement that individual service users /principals would have the skill and knowledge to make informed purchasing decisions if given the freedom to manage their own care budgets. This contrasts with the weaknesses in community care type markets predicted in the work of Le Grand (1993) and Barlett and colleagues (1998) and outlined in chapter two. Practitioners' accounts supported the suggestion that bureaucratic purchasers/ agents are unable to judge the quality and appropriateness of services provided through council contracts.

Practitioners had few expectations of 'knaveish' behaviour from users or their carers (Le Grand 1997), which is arguably the premise on which market theory rests, that is that individuals will

pursue their own self interests to the exclusion of others to maximise utility (Greener 2002). In 2000 over a quarter of the practitioners predicted that users would improve the quality of their care by establishing relationships with staff. The consistency and compatibility of care staff have been identified by research into service users' views as important indicators of quality services. Local authority contracting arrangements nationally were generally failing to secure them. (Henwood 1998 and 2001, Turner 2000).

Care managers in Fletcherford who arranged care for individuals were generally not permitted to trade off cost and quality considerations in purchasing decisions because they were obliged to commission services through the council's contract, which set an hourly rate for domiciliary care. Where practitioners had the authority to use specialist providers they were informed by reputation like their peers in Mannion and Smith's (1998) research, but reputation in this social context was based on users' accounts of their experiences. Practitioners felt that users would be able to trade off cost and quality considerations if empowered to do so through direct payments. In contrast to the social workers in Lapsley and Llewellyn's (1998) research, Fletcherford practitioners did not use wage levels offered by independent sector providers as a crude indicator of quality. Rather they drew entirely on users' opinions and did not challenge the appropriateness of the criteria users' employed (consistency, reliability and attitude of staff). Even the four practitioners who had reservations about the potential outcomes of direct payments for service users, did not question that users were the best judges of the quality of the services they personally received. Practitioners used low wages to explain the recruitment and retention problems experienced by independent sector agencies, which they in turn blamed on the council's budgeting and contracting practices, as well as the profit motives of providers. Like the care managers observed by Knapp, Hardy and Forder (2001), it seemed that practitioners in Fletcherford were well placed not only to identify and respond to individual needs but to make judgements about the cost and quality of alternative services. However, as in most councils Knapp and colleagues studied, they were not budget holders and, like service users whose opinions they promoted, they appeared to have little influence over contracting decisions.

Practitioners' regarded direct payments as an individualist model of service provision and there was little mention or consideration of any potential value in collective terms. Most practitioners expressed support for direct payments and many were enthusiastic at the prospect of being involved in their introduction. However their aspirations were fairly modest and couched in terms of improving the quality of life of individuals rather than shifting the balance of power from political and bureaucratic decision-makers to local disabled people. Some practitioners drew a distinction between the additional choice and control that users could exercise over their own care arrangements as 'paying customers' and the power that having real influence over

local policy development and services strategies would imply. This resonated with Jordan's (1999) distinction between consumerism and empowerment. A quarter used the language of individual rights and citizenship, together with the concept of empowerment. Practitioners did not think that most users seeking direct payments, would want to combine with others to run their own services. Nevertheless they felt that there were articulate individuals and users running local voluntary groups that could, and should, be involved in the development and delivery of support for direct payment users. They thus distinguished that there are levels of participation (Arnstein, 1971) as well as alternative models of participation, consumerist versus democratic (Beresford and Croft, 1993) appropriate to different individuals.

Practitioners recognised that the degree to which individuals would welcome greater involvement in the decision-making that affected their lives would vary with their circumstances and experiences. They distinguished potential 'active' from 'passive' citizens and were concerned about the 'pawn' - like acquiescence of a minority of service users and their vulnerability to abuse by instrumentally motivated 'knaves' (Le Grand 1997). They were also worried that people may be deterred from requesting direct payments if, in addition to managing their care budget and organising their care, they would be required to assume the responsibilities of being employers. This concern was not usually framed within a 'care discourse' that describes service users as irresponsible or unable to manage their own affairs. Instead they suggested that this reluctance would be because users and carers were already overwhelmed with the stress of coping with illness, pain and impairment along with lack of relevant experience, rather than lack of competence. Thus those who said that they would choose to have a direct payment to meet their own care needs explained that their employment experience would have privileged them with appropriate knowledge and confidence. Direct payments were also discussed as a means of enhancing personal development. Fletcherford practitioners therefore supported the implications of the work of Taylor-Gooby (2001), Barron (2001), Hoggett (2001) and Greener (2002) that users' ability and inclination to take greater responsibility for their care arrangements would depend on their past experiences.

Like the health minister (quoted in chapter five), the practitioners who did not agree that users should be able to get direct payments in lieu of health care, prioritised the collective value of equality over individual choice and control over service delivery. Money in lieu of services was generally regarded as a potential source of empowerment and improvement in social care, redressing social injustice brought about through the commodification of care relationships into hourly units through the mixed economy. However cash for health care was perceived as having negative implications for services, causing social injustice by undermining collective values and provision.

The government intends to increase 'choice' for service users in its overall plan for modernising social services (Dept of health 1998a 2.62). Choice is promoted as a desirable policy outcome and the weight it is given in policy guidance on direct payments is increased in the most recent version:

'The government's aim in promoting direct payments is to increase users' independence and choice by giving them control over the way the services they receive are delivered.'
(Dept of Health 2002, para 7)

This echoes the original community care guidance issued by the Thatcher government:

'Promoting choice and independence underlies all the government's proposals' (D.H.S.S. 1989, 1.8)

It is not always clear whether choice in the context of community care policy is promoted as a means or an end. Choice in the Conservative's approach appeared to be an essential element of a consumerist strategy intended to impose market discipline on providers, obliging them to offer the service customers wanted at the price they were willing to pay, or risk losing their custom to competitors. Choice may be a pragmatic means to the end of ensuring that users can specify the service they want rather than be obliged to accept what is available, the *'one size fits all'* approach condemned by Blair's government (Dept of Health 1998a, 1.7)

In Fletcherford three quarters of the practitioners saw 'choice' as one of the potential benefits to be gained by users opting for direct payments, but in their responses choice was associated with flexibility. Choice would be the means to the modest outcome for users of being able to determine when and how their care is delivered and by which individuals, and to change their care arrangements to suit their personal circumstances. The benefit of choice for users would not be achieved by 'shopping around' for alternatives or individual 'exit' strategies, but by securing the 'best fit' to their preferences from the service arrangements they already experienced.

Practitioners recognised the limitations of choice in the context of the community care market and their views gave validity to one critique of choice in the literature. Barnes and Prior (1995) argued that if the market or any other allocation system provides what is wanted, the presence or absence of choice in the form of alternatives is irrelevant. Choice may be experienced as risk. Choice may be threatening if the individual lacks full information about options available and the implications of alternative decisions. Choice may be unwelcome if the individual has had no influence over the range of options offered or input into the economic and political decisions that set the parameters of that range and has not had the opportunity to develop skills in choosing. In Fletcherford practitioners felt that many users had been dis-empowered by the withdrawal of the public services they trusted to meet their needs and preferences to an

acceptable, predictable standard. Offering people the choice of a range of alternatives, that were the outcome of decision making processes to which they had not contributed, was not perceived by practitioners to be a means to the end of increased user satisfaction. Many practitioners seemed to agree with the councillor who suggested that choice offered by community care to social service clients was 'tokenistic', because they did not have the control over budgeting and purchasing decisions enjoyed by people able to pay for their care from their own resources (Chair of the Scrutiny Committee, quoted in chapter five). Practitioners, like most of the local Labour politicians, were of the opinion that direct payments would give people a more genuine choice than that offered by a range of poor quality, unreliable independent agencies. However they believed it was a choice many service users would have preferred not to face.

Choice however is also promoted in policy documents and advanced in the literature as an end in itself, associated philosophically with individual liberty and civil rights (Barton 1993, Morris 1993, Oliver and Barnes 1998). Practitioners in Fletcherford suggested that giving users recognition as people who have choices could of itself be empowering. This is not just a matter of the psychological well being of the 'reflexive citizen' (Giddens 1998, 2000), or a return of the sense of personal dignity and emotional security that practitioners suggested users lost when they did not feel they had any control over their care arrangements. Choice has a social dimension, conferring a status on the disabled person. In the accounts of practitioners this status seemed to have the value of the 'symbolic capital' described in Greener's (2002) critique of the assumptions made about agency in New Labour's social policy (discussed in chapter two). The *habitus* of the user may elicit a more responsive service in interactions with welfare agencies, where her status (social capital) is recognised. However practitioners demonstrated an awareness of the relevance of cultural capital (information) and economic capital (control over spending) to users' ability to get full benefit from the community care system as both consumers and citizens.

Lack of information about direct payments was identified by practitioners as potentially the major obstacle to their spread in Fletcherford. Nevertheless, as the next chapter will reveal, those leading the implementation of direct payments deliberately opted for a 'low key' approach to publicising and launching the scheme.

CHAPTER SEVEN

Participation in planning and policy development

'Progress will be obstructed by some ... who openly disagree with the principle of self-determination, or with the idea that people should be the purchasers of their own support services. ... But, I predict, the main and most effective threat to progress will come from the 'the service system' the professionals will make themselves more expert on self-determination than the people who originally demanded it People with disabilities won't be allowed and enabled to achieve self-determination; they'll have it delivered to them.' Dowson (2000)

7.0 Introduction

An account of Fletcherford council's interpretation of the government's advice to involve disabled people in the development of direct payments follows. Its implications for the design of the local scheme are explored. During the planning process, the intermediate objectives (policy means) of both participation and direct payments displaced the ultimate objectives (policy ends) of promoting independence, as power and status proved to be more influential than relevant knowledge and experience. The chapter begins 'at the top' with the government's approach to involving disabled people in policy development and implementation. An explanation of the organisational environment for the implementation of direct payments in Fletcherford follows. Next, a description of the two planning groups established by the council, involving service users and voluntary sector representatives alongside 'professionals', is presented together with an analysis of the progress and outcome of their deliberations. This account shows how the obstacles to effective policy action through participation included the potential problems identified by practitioners earlier and also the government's own emphasis on performance management and measurable results.

7.1 Central government and participation

Participation was central to New Labour's approach to improving policy effectiveness and drew on Giddens' (1998, 2000) concepts of the modern 'reflexive society' and the 'active citizen'. The government encouraged the participation of users in the planning and development of local direct payment schemes (Dept of Health 2000a). At the national level, the Department of Health led by example in funding an organisation run by disabled people (the National Centre for Independent Living) to assist. Disabled people were consulted on the proposals to extend the initiative and involved in the drafting of new guidance:

'They recognised all the expertise was in the disability movement: direct payments developed in the disability movement.' (Co-director of NCIL, June 2001)

Andrew Holman, a campaigner for direct payments for people with learning difficulties, supported a group of users who were invited by the Department of Health to participate in the development of the government's National Learning Disability Strategy. Users helped produce

an accessible 'Easy Guide to Direct Payments'. Holman (2000) summarised New Labour's attitude in the phrase 'the listening government'. Leaders in the disability rights movement therefore believed that the government's efforts to ensure participation were genuine.

'The best direct payments schemes have been developed by local authorities and users working together to draw up a scheme that meets local needs.' (Dept of Health 2000, 11 para. 3)

The following account is based on:

Table 7.1 *Data Sources and Collection methods*

<u>Method</u>	<u>Source</u>
<u>Documentary analysis</u>	Department of health policy guidance, chief officers' reports to the elected members on Fletcherford council and minutes of planning group meetings.
<u>Participant observation</u>	The 'Reference Group' responsible for key decisions on the implementation of direct payments;
	The 'Working Group' responsible for the development of a local support service;
	Meetings of senior, operational, contracts and planning managers;
	Meeting between the Planning manager (1) and the internal auditor;
	Day to day activities and discussions/ reflections on practice and policy issues within social services offices.
<u>Interviews</u>	The co-director of the National Centre for Independent Living;
	The strategic manager with lead responsibilities for policy implementation;
	The first and second planning managers with 'portfolio' responsibility for the implementation of direct payments;
	Senior operational managers for care management teams;
	Care management team managers including the representative on the Reference and Working groups;
	Local authority internal auditor, responsible for advice on policy development and implementation issues on the Reference Group;
	The Contracts Manager ;
	Service development manager, responsible for joint health and social care policy issues;
	Health service managers responsible for developing policy and practice on joint health and social care issues;
	Practitioner representatives on the groups responsible for the introduction of direct payments;
	Four user and two carer representatives on the 'Working group';
	Committee members of the local umbrella organisation for voluntary groups of disabled people (disabled people who were 'active citizens' in their community);
	The co-ordinator of the local umbrella organisation for voluntary groups of disabled people;
	The co-ordinator of the local voluntary organisation supporting carers;
	The manager of the local voluntary sector development agency.

7.2 The organisational context

As predicted in the policy studies literature discussed in chapter 3, the organisational context proved to be relevant to the process of implementing direct payments.

My impression, from observations of day-to-day activities and relationships within Fletcherford social services and interviews with staff, was that it was a supportive working environment. Power struggles and conflict between different teams or interest groups were not apparent and there were no general complaints of low morale within 'care management'. There was no obvious animosity to management or resistance to the changes promoted by central government. Most staff said that they supported the proposals in 'Modernising Social Services' and believed that they were consistent with the values, aims and practice of the local authority. Nevertheless three factors interacted to affect the operation of social services and had an impact on the policy implementation process.

7.2.1 'Implementation overload'

Team managers said in interview that they had difficulty managing the current demands for services properly, while preparing for change. They were therefore obliged to 'choose' what to focus on according to their own priorities. They all mentioned the following pressures.

The move to greater integration with health services:

'At the moment there is so much going on with integration and the National Service Framework that I am just not giving direct payments much thought.' (Team manager 2)

The higher levels of dependency of social service clients with the move from hospital care to supporting people at home:

'The government says we have too many people in residential care, we are told to reduce the numbers. We have a history of heavy industry, asbestosis, chronic chest problems. We have a lot of very poorly people and we are told we must maintain them in the community.' (Team manager 4)

The pressure to demonstrate the achievement of performance targets:

'Nothing is set up properly to begin with. It is done quickly for expediency, but I am being asked to produce figures all the time.' (Team manager 1)

Direct payments were seen by some managers as just one of a series of policy initiatives with laudable goals:

'Generally the underlying aims are better services, more flexibility, more options.' (Team manager 7)

Managers felt that requests for direct payments should be referred to more skilled staff, but they all described a shortage of experienced practitioners to whom they could allocate the more complex work:

'If staff do not sound confident it will put people off.' (Team manager 1)

They also described the difficulties in keeping staff updated on developments, for example.

'I've got [the information team manager] coming to the team meeting to talk about how we get the new assessments and care plans onto the computer. [The director] wants to come to the next one to talk about re-organisation. I do not know when we will have a chance to hear about direct payments.' (Team manager 1)

One manager summed up the tensions all his peers had identified:

'I feel we are at a watershed. Social work practice has moved towards technical, 'tick box' responses over the last ten years. With community care there has been a loss of long term planning and relationships, the short-term focus on immediate needs means it is a revolving door for referrals. We are now moving idealistically in the right direction, but I am worried we are setting ourselves up for failure with grand designs and unrealistic time scales. If we have not got the resources to match the ideals, it is just rhetoric.'

(Team manager 6)

7.2.2 Re-organisation and personnel changes

An internal re-organisation of care management and 'commissioning' functions, took place between April 2000 and 2002. This was explained as follows:

'Local strategies and national policy requirements demand an increasingly sophisticated approach to commissioning, both to assess need and ensure that services are meeting the policy objectives of the personal social services and particular policy initiatives. ... Central government over recently years has frequently imposed very tight time scales for social/ health care initiatives.'

(Chief Officers' Report to Social Services Board, March 2000)

Senior posts were usually filled through internal promotion. Staff working for shrinking 'in-house' services were redeployed to vacant care management posts and the department recruited new practitioners from social work students on placement. However re-organisation in response to policy change contributed to recruitment and retention problems and increasing demands for training and information.

Policy changes created new opportunities in the implementation of the government's 'modernisation' programme nationally; many staff moved for promotion. Posts not filled by internal applicants sometimes remained vacant for months. Many care management practitioners were inexperienced. Managers needed to ensure a through-flow of clients to be able to respond to emergencies. Referrals were 'juggled', balancing pressure to meet performance targets and fulfill statutory duties against the imperative to develop skills in new staff.

Changes in key personnel had implications for continuity in the planning and implementation of direct payments, during these two years. The resignation of the planning manager, with lead responsibilities for direct payments, in August 2000 was critical. Her post remained unfilled until September 2001. Other changes in key personnel included the director of social services, both heads of operations, four (of six) team managers in care management and the contracts manager responsible for direct payments. There was also turnover in the practitioner teams. In learning disability services only one of the original care managers remained in post in April 2002 and the mental health team struggled to recruit and retain staff to carry out statutory duties.

A problem that was exacerbated during this period was the loss of skill and experience reported elsewhere with local authority re-organisation (Craig and Manthorpe 1999). Fletcherford, as a new unitary authority, had begun to deliver social services with staff re-deployed from other council departments. Managers with social work backgrounds commented that those leading the planning and policy implementation processes had little awareness of community care users' needs and the complexities of the social work/ care management role.

'On the planning side I am worried about the lack of people with a social work background....or 'people' knowledge and skills. Lack of user focus in planning is one of the reasons I'm leaving.' (Planning manager 1, in interview, August 2000)

The planning manager's resignation meant that the strategic manager was the only social service officer with continuous responsibilities for direct payments throughout the planning and implementation period.

7.2.3. The pressure to perform

In the autumn of 1999, the Social Service Inspectorate's basic 'position statement' (performance report) had revealed that Fletcherford was not making direct payments. New government guidance instructed councils to consider requests for direct payments, whether or not they had a 'scheme' already (Dept. of Health 2000a). A survey commissioned by the Association of Directors of Social Services (Jones 2000) revealed that Fletcherford would be one of the last nine of 171 local authorities in England and Wales to introduce direct payments. The strategic manager felt that the pressure was mounting; *'we are going to be criticised if we do not get a basic direct payments scheme up and running'* (July 2000). She was given responsibility for the introduction of direct payments. She had hoped gradually to delegate responsibilities for leading the process to the planning manager, who had a particular interest in disability rights issues but the latter's resignation in August 2000 would prevent this.

7.3 Planning Groups- Membership and Terms of Reference

In April 2000 the director of social services won political approval, to establish two planning groups to develop a direct payments scheme. The tasks involved were split between them.

The Reference Group was composed of a core and peripheral membership. The core members were senior strategic, planning, contracts and operational managers from the social services department. A service user and two voluntary sector managers, as well managers from the community health and primary care trusts, represented views from outside the authority.

The intention was that the core group would draw on the specialist advice of professionals from other council departments who could also represent 'corporate' concerns. These 'peripheral' members included the principal solicitor, the head of internal audit and the social services principal finance manager. The 'Cabinet' was asked to nominate a councillor to join the Reference Group, but none attended (Director's Reports to Cabinet, April and August 2000).

The responsibilities of the reference group were:

'Developing internal systems, overseeing the contracting process, establishing the scheme, reporting to Departmental Management Team and to elected members' (Director's Reports to Cabinet, April 2000).

The Working Group was composed of community care users and carers; two voluntary sector managers; the strategic manager, the planning manager, a care management team leader and two care managers. The responsibilities of the Working Group were:

'Researching and developing an appropriate direct payments model, researching and developing the preferred model of support scheme, overseeing wider consultation, commenting on the development of internal systems, reporting regularly to the reference group.' (Director's Reports to Cabinet, April 2000).

The rationale for the separation of tasks between two groups was to make effective use of management resources needed for the whole policy implementation programme. Senior operational managers were too busy with wider 'modernisation' responsibilities to commit time to the detailed implementation of one initiative:

'Having a reference group was suggested by the assistant director, because senior officers are involved in so many meetings they should not have to get involved in 'nitty gritty' stuff.' (Planning manager 1, June 2000)

The strategic manager said that she hoped to encourage wider ownership of the responsibility for introducing direct payments, by involving senior operational managers in key decisions. She did not want direct payments to be seen as just another initiative that could be left to policy and planning staff to implement.

'At the end of the day, it is going to be their staff (care managers) that sell direct payments to users and their budgets that pay for them.' (Strategic manager, Resources and Planning, March 2000)

It was also intended to spare users and carers from the tedium of discussions about the development of the internal procedures and systems required to introduce direct payments. Examples of 'internal' issues included: the procedures for arranging direct payments, the method of calculating the rate, and the wording of documentation.

'I think dividing the groups the way we have is logical, in that there is a lot of dry internal stuff that service users do not really want to get bogged down in.' (Planning manager 1, June 2000)

The Planning manager hoped that users and carers would get the opportunity to comment on the proposals for developing internal systems.

'There are going to be some crucial decisions made in the reference group that service users need to be able to comment on. I have hoped all along that even though the reference group will work up the technicalities they do not see it as a rigid divide. There should be dialogue and people should be very much involved in the contracting process.' (Planning manager 1, June 2000)

It was also recognised that senior officers might feel uncomfortable about discussing the implications of alternative approaches to implementing direct payments, in the presence of people who could be personally affected by their deliberations.

'I think that it is a pragmatic approach to some extent in that if it was just one big group it would be difficult and officers would feel more threatened' [by the presence of service users]. (Planning manager 1, June 2000)

Nevertheless the rationale for splitting the implementation tasks between two groups was not clear to everyone. The manager of one of the two local voluntary organisations who regularly attended the both groups, said that she thought that all those involved could have been sharing their concerns and developing the local response together.

'Why two groups talking about the same things?' (Users Voluntary Organisation manager, in interview May 2001)

7.4 The Reference Group

The group met nine times between June 2000 and September 2001.

The first meeting was planned to inform a broad group of 'stakeholders' of the council's intention to introduce direct payments and was the best attended with ten people from an invited membership of sixteen. Attendance fell subsequently and the average number of people at each meeting was six. Excluding the strategic manager, who chaired all nine meetings, each member attended three times on average. When senior operational managers from social services failed to attend early Reference Group meetings the membership was extended to more 'junior' staff, a team manager and social worker, who were also members of the Working Group. Attendance still fell and the Reference Group was eventually amalgamated with the Working Group following an aborted meeting in September 2001 when only two people attended.

7.4.1. Data from observations and interviews with participants

At the outset the planning manager had anticipated two problems with the operation of the Reference Group. The first was that senior operational managers, would be too pre-occupied with 'bigger issues' to prioritise attendance, despite their knowledge of community care locally and awareness of users' experiences. Her fears were realised in their regular absence from meetings. The senior operational managers explained their poor attendance by reference to the demands on their time from the large number of policy initiatives generated by '*Modernising Social Services*' (Dept. of Health 1998a) and subsequent legislation. These managers, who voiced broad agreement with the principals of direct payments, seemed to decide that the initiative was not central enough to the overall policy programme to merit priority over competing work pressures. The planning manager did not expect that senior operational managers would deliberately obstruct the process of introducing direct payments:

'Amongst senior management I have not picked up any hostility to it, I think people are still finding their way through it, but I do not hear anybody particularly championing it... I get a sense of "I suppose we have to do this".' (Planning manager, August 2000)

Poor attendance at the Reference Group was a continual source of concern for the strategic manager, particularly as those who did attend most consistently were also members of the Working Group. She was the only member of the social services management team who regularly attended direct payments planning group meetings and so kept aware of developments and issues raised. Therefore when there was conflict with other senior managers, who were resistant to the introduction of direct payments, she could not call on much support from her peers in operational management. Although they were in favour of the principles of direct payments, they were not sufficiently informed to address counter arguments. Health service managers attended more frequently but not regularly enough to contribute an inter-agency perspective to the planning deliberations. Most of the people who attended Reference Group meetings appeared to be there to give token support to the initiative and to be updated on progress, rather than to play an active part in planning.

The planning manager's second concern was that there were senior officers in the authority who had ideological objections to the government's policy, and who would use the decision making processes to obstruct progress or to dilute the effects.

'I think the solicitor is going to be like a dog with a stick. I think she is going to be a pain in the neck, because she is so down on it so she is looking for problems.' (Planning manager 1, August 2000)

The director and assistant director agreed that the contributions of two senior professionals, the principal solicitor and the head of internal audit, were crucial to the successful implementation of direct payments because of their influence on councillors. At the beginning of first Reference Group meeting the solicitor asserted that the extension of direct payments was being imposed inappropriately on the council by central government. She referred to the 1997 'consultation'; *'the good people of Fletcherford were consulted and have very wisely said no thanks'*. The solicitor also suggested that criminals would be attracted to the town by direct payments. Her opposition set the tone for this and subsequent meetings she attended, placing the strategic and planning manager on the defensive, having continually to justify the decision to introduce direct payments rather than to focus on the practical issues of implementation.

This planning manager's approach to resistance was similar to that of her director, who had 'sold' the initiative to local politicians with the assurance that *'it will not have much impact'* (see chapter 5). She similarly tried to defuse opposition, but with reservations:

'I do not like selling it that way: "don't worry take up is usually low". That is generally how it is, but it's not what I hope for. I hope there is a very high take-up and I hope it is going to have an impact on services. It may affect people's jobs, but my view is at the end of the day we are here to protect service users, we are not about protecting people's jobs. I know that is a simplistic view but that is where I stand with it.' (Planning manager 1, June 2000)

The planning manager also expected covert resistance from the contract team in social services, because their manager had repeatedly queried why the department was introducing direct payments when the council had 'a power, not a duty'. She suggested that this resistance was due to lack of understanding of the needs, preferences and situations of community care service users amongst contracting staff. The strategic manager seemed committed to the principles of direct payments. She was however concerned to avoid any conflict in the Reference Group that could lead to the withdrawal of the (however luke-warm) support of powerful colleagues:

'She (the strategic manager) tries to appease the solicitor to keep her on board and I do not think she is going to be kept to her role. [the solicitor] confuses her role with her opinion about a whole range of things she is not qualified to have an opinion on and there is other expertise in the room that is not used.'

(Planning manager 1, August 2000)

The strategic manager however offered an alternative explanation for her response to the solicitor. ' [the solicitor] just wants to protect people. She is worried about leaving people vulnerable.' (Strategic manager, September 2000). Another manager suggested that the solicitor's behaviour reflected a 'risk aversion' typical of social actors in similar roles: 'Local authority solicitors are not risk takers. If they were they would be in private practice, making loads of money.' (Operational lead manager, September 2000)

The auditor also had reservations about the wisdom of passing public money to service users to arrange their own services. He expressed the support for collectivist principles that the council should be directly providing services of the quality and type that people prefer, rather than abandoning users to the community care market. He was concerned that users with extra money could be vulnerable to exploitation.

'We may no longer have the legal responsibility [for direct payment users] but we are morally and ethically responsible for making sure people are properly cared for....'
(Head of Internal Audit, Reference Group meeting, June 2000)

Nevertheless the planning manager was able to alleviate the auditor's anxieties, by providing him with the relevant guidance (CIPFA 1997). She met him separately to address his concerns with explanations of how other councils had dealt with potential risks. The auditor accepted these 'appeals to reason' and evidence that conflicted with his original views, suggesting that his own objections were not ideological. He continued however to be cynical about the usefulness of most central government guidance in policy implementation:

'It is basically 'cover your back' legislation by this and the last government. Laying it down but virtually impossible to do anything with it.' [Auditor]*

The auditor explained that while he would have preferred to see effort going into improving the council's own services for all, he could appreciate the potential benefits for some individuals. The auditor's 'paternalistic' attitude to service users did not seem to be based on pre-judgements

about the capacity and probity of social services clients, but rather about the general public who are not trained accountants and who he referred to as 'civilians'.

'I appreciate the philosophy, but whenever civilians are involved in handling money it is a nightmare. We audit voluntary and community groups as a favour. From my experience of civilians, to expect them to do monthly reconciliation, filling in time sheets etc is quite daunting. Most do not even reconcile their bank statements.' [Auditor]*

The auditor reassured the planning manager that despite his personal reservations his department would not be deliberately obstructive or demand rigorous monitoring procedures that might deter people from using direct payments:

'We are not trying to put barriers, we are not going to stop you, we are not going to be over critical... I am in favour of keeping it simple. It would be a shame to put people off because of the paperwork' [Auditor]*

The planning manager was less successful in eliciting the co-operation of the solicitor, whose unwavering attachment to her original objections to direct payments appeared to be based on a 'care discourse' (Morris 1993). The strategic and planning manager tried to allay her concerns with examples of successful practice in other areas, however her response was always that she was not interested in what happened anywhere else, and that her role was to protect the Fletcherford interests. The solicitor, despite being a 'peripheral member', attended more Reference Group meetings than senior operational managers. Her presence ensured that her particular interests dominated the meeting. However low attendance by key decision-makers meant that proposals for local policies and procedures for direct payments were developed outside the group and brought forward for ratification. While the Reference Group appeared to have decreasing significance, it was still attended by community representatives from the Working Group. The strategic manager tried to make all members of the group feel comfortable and to encourage them to contribute to discussions. However the service user, who usually spoke confidently in the Working Group, rarely spoke. He explained:

'I felt most of the discussion was over my head, I did not know what the solicitor was talking about most of the time. I am sure she knows her stuff but it meant nothing to me, but I hung on in there.' (User representative, in interview, December 2001)

Ironically this man, as the co-ordinator of an Information Service for the local disabled community, was one of the people on the Reference Group with the most knowledge of direct payments. He also had several years' experience of using community care services and therefore had the ability to judge the practical implications of the 'implementation issues' the group was intended to address. Furthermore he was identified in interviews by many council staff as their main source of information on direct payments.

* * Observation of meeting between Planning manager and Auditor July 2000.

The planning groups combined to hear a presentation by the Support Service (to be discussed below). Despite the presence of several service users the solicitor explained her concerns about passing on responsibility for the management of public money to individuals through direct payments:

'We can assume these people are not used to having a lot of money; if they were they would not be coming to us for services.' (Solicitor, January 2001)

For this council 'expert', the selective/ residual principles on which social services had been founded continued to stigmatise their users and support a 'care discourse'.

7.5. The Working Group

One of the major tasks allocated to the Working Group was;

'Researching and developing the preferred model of support scheme,' (Director's Report to Cabinet, April 2000).

The original planning manager had hoped that Working Group members would have an active part in developing a support service in partnership with a local voluntary group:

'I mean inviting a few people on to the working group is one thing, but that is not enough. We need capacity building with a local organisation to possibly take on the support service' (Planning manager 1, June 2000)

However before the group first met, senior managers in social services had begun discussions about commissioning an organisation based in a neighbouring authority (Macville) to support direct payment users in Fletcherford. The Head of Contracting recommended this in preference to going through the process of developing a direct payment scheme in partnership with local people as recommended in government guidance (Dept. of Health 2000a).

7.5.1. Participation

There were six users and two carers invited to join the Working Group, out of a total membership of sixteen. There were two voluntary sector representatives, the managers of the Users' Voluntary Organisation and the Carers' Group, and six social services employees: the strategic manager, the planning manager, a contracts manager, a social work team manager and two social workers. The eight paid staff and one of the users were members of both planning groups. Because more senior council staff were members of the Reference Group only, it was local people and senior officers who were separated by the division of tasks between the two groups.

Representatives of users of services for people with physical disabilities, sensory impairments, learning disabilities and mental health problems, volunteered to participate. The Carers' Group nominated a carer and one user brought her husband. There was no older person on the group.

However the carer of two older people, who were waiting for direct payments, eventually attended two meetings. The planning manager explained how she was able to capitalise on 'top-down' pressure for user participation:

'With direct payments, it could have been a fight, getting so many users and carers on the working group, but I have been able to back it up with so many government initiatives it makes it easier to give that legitimacy to working that way.' [Planning manager 1, June 2000]

The planning manager visited each person at home before the first meeting and identified any special needs. She set up a 'buddy system', which meant that each user and carer had the individual support of a paid worker. Travelling expenses, were reimbursed. Users were also encouraged to bring their own support workers. They were given background information on direct payments through a variety of media, and they heard about experiences of direct payments from disabled people from other areas. The extent of the efforts made to facilitate participation was recognised as unusual by the representative of the Users' Voluntary Organisation:

'It is hard work including disabled people, arranging transport, access, assistance etc. They usually hold big one- off consultation events but the agenda is set by social services.' (Interview, May 2001)

The strategic manager supported the planning manager's efforts to ensure that user participation was meaningful. However by the first meeting of the Working Group in August 2000, the planning manager had given notice that she was leaving. She was concerned that without her contribution, senior management would choose to buy in a support service developed by another authority. While this would relieve the pressure to demonstrate progress in introducing direct payments, it would effectively deprive local people of the opportunity to be involved in the development of their own scheme.

'I am worried that [Fletcherford] may just go in with another authority for convenience sake rather than because it is the right thing to do. I see it as part of the development of a whole range of things in terms of capacity building in communities and individuals, but nobody else seems to be looking at it in that way. It is just "lets have a scheme... pay someone to do that and forget it"' (Planning manager, August 2000)

The first planning manager thus saw user participation as more than an end in itself, but as a learning and confidence building opportunity. Participation could give local people the skills and knowledge to develop their roles as the 'active citizens' of the third way ideal. As she had explained in an earlier interview:

'Direct payments are an excellent example of people doing things for themselves..... It can develop all kinds of skills in people that can be transferable to jobs, that sort of thing. I do not think people have twigged to that whole, very important by- product.' (Planning manager 1, June 2000)

7.5.2 Attendance

The Working Group met fifteen times between August 2000 and May 2002. Meetings were always better attended than those of the Reference Group, with 100% attendance at the first meeting and over half at five others. This was due to the regular presence of social services staff and voluntary sector representatives. Their average attendance was 8.5 meetings each. The voluntary sector representatives were the best attenders at both planning groups. The attendance of users and carers fell steadily and most significantly after the introduction of the support service. Only one user attended from March 2001, and no users attended from November 2001. The rest of the users and carers attended an average of 2.5 meetings each. After the two groups merged there was no further representation from the local community. Support service staff began to report to meetings from March 2001.

The atmosphere was very relaxed at the early meetings. People were given the opportunity to ask questions and to explore their concerns and preferences for a support scheme and seemed comfortable exchanging views. Payment rates were an issue of particular concern to users from the beginning. At the fourth meeting the Strategic Manager advised the group that the council was considering bringing an organisation based in another area to provide the support service in Fletcherford, but that they would be invited to hear a presentation before the contract was awarded. The Macville based support service made its presentation at the following meeting. I will discuss the conduct and content of this meeting to illustrate how it represented a critical point in the implementation process, in that the nature of community 'participation' in the development of the direct payments scheme changed.

7.5.3. Enter the 'Experts'

The manager of the Macville based support service gave a presentation to the Direct Payments Planning Groups. Her objective was to 'sell' her expertise in the hope of winning the contract from the council to support direct payment users in Fletcherford. She therefore needed to convince potential funders that direct payments were sufficiently complex to warrant buying in expertise from an outside agency and that her organisation had the technical knowledge required. It was therefore understandable that her presentation was focused on what were the usual concerns of council managers and couched in technical language or jargon.

The solicitor was present and dominated this meeting, interrupting the flow of the presentation with questions usually on legal points, her own area of expertise. For example her first question was about the liability of direct payment users as employers. The support service manager responded that a standard condition of receiving a direct payment was that users obtained 'employers' liability insurance'. The solicitor seemed to disregard this response, announcing to the group that:

'It is most unfair to employees. A contract of employment is based on mutual trust, you expect them to be honest and loyal, they expect you to protect them'
(Solicitor, meeting, January 2001)

The implication of this statement seemed to be that she was not convinced that direct payment users could be trusted to be responsible employers.

The solicitor continued to dominate the subsequent discussion with legal issues around capacity that clearly did not engage the rest of the group. The support service manager ultimately seemed to satisfy the solicitor. She gave assurances that her organisation would ensure that only people who were 'capable' would receive a direct payment, although restricting access had not been discussed as one of the duties of the support service. Only two other members of the group asked a question: the social worker who asked about the procedures for arranging a direct payment and a senior health service manager. The latter asked how health and social care needs were distinguished elsewhere, in the light of the reviews of 'continuing care' responsibilities happening nationally. The manager replied that people with health care needs were excluded from direct payments in Macville, and acknowledged that this was the only other authority she knew. This brief response from the 'expert' on direct payments was assumed to have implications for potential users in Fletcherford and influenced senior managers' expectations of the limitations on their use. It would be an obstacle to be overcome by practitioners arranging direct payments for people with complex needs.

The interaction between the support service manager and the solicitor set the tone for subsequent meetings. Although the solicitor's role was advisory, she dominated the discussion with questions that seemed intended to test the 'expertise' of the support service. The reason given to the planning groups that Fletcherford contracted in a ready made scheme, was to short cut some of the development work and avoid having to design their own information materials. The manager produced a file of guidance notes her service had produced on direct payments that had passed muster in the other area. However the solicitor was not prepared to accept that materials produced for another authority would be adequate and seemed determined to ensure that her own 'expertise' controlled the development of the scheme in Fletcherford, as the following discussion illustrated:

Solicitor *'You've got the information wrong on Enduring Powers of Attorney.'*

Support service manager *'We spent four weeks checking it out with the lawyers, but if you want us to say something else, you tell us what you want us to say.'*

Solicitor *'I would like to see the information you give on employment. But I want to see a balance, all the disadvantages of being an employer. The responsibilities spelled out.'*

Strategic manager *'There is an advantage in having a common approach across the two authorities, using the same material'*

Support service manager *'We can provide whatever material you want.'*

(Reference Group Meeting 6, March 2001)

This exchange demonstrated how the solicitor sought opportunities to deter people from requesting direct payments by making them appear very onerous to manage. It is also an example of how the support service manager deferred to the solicitor, even when she believed she was wrong, despite the offer of support from the strategic manager. It was recognised by social services staff that the solicitor was opposed to direct payments and would do whatever she could to obstruct their development and to limit their impact. Like social service managers, the support service manager's approach was to try to 'appease' this powerful opponent.

I do not know what the support service manager's approach to introducing her organisation to users and carers would have been had she not been subjected to the barrage of hostile questions by the solicitor at the first meeting. However in subsequent meetings with the Working Group she continued to use technical jargon to which the users and carer present did not respond. For example she promised that her Support Service would provide 'capacity building', 'signposting' and 'additionality', and nobody asked questions. The use of terms that were meaningless to members of the public clearly acted as barriers to their participation.

When the Working Group was given the opportunity to comment on the presentation made by the Macville based support service,¹⁸ they did not do so. Conversations with participants afterwards revealed that they accepted that the decision to commission support from this organisation was a 'fait accompli'. The discussion focused on two concerns shared by users and practitioners. The first was that direct payments could be subject to 'ceilings', that is pre-determined limits on the amount to be spent on a care package. The second was that re-assessments against revised 'continuing care' criteria could exclude people from getting direct payments. Users and carers understood the practical implications of these issues, just as they did with the issue of the direct payment 'rate', and felt qualified to comment.

In March 2001 the strategic manager presented a draft report to the group she had prepared for the approval of councillors. Her report recommended that Fletcherford council contract with the Macville based support service and introduce a direct payment scheme using the model developed in the other authority, buying in two days of a support worker's time. The strategic manager explained that the proposal was to contract through a neighbouring authority for a year *'just to get a fairly modest scheme up and running'*. She maintained that the work would be put

¹⁸ Although the Support Service did not have the name of the town in its title, it was generally referred to as the 'Macville scheme' and its manager as the 'Macville woman'.

out to tender after a year and local organisations would then have the opportunity to apply for the contract.

'It gives us a year to see how it goes, to sort out teething problems. It means that support will be there for the first few brave users.' Strategic manager, Working Group meeting February 2001.

At this meeting it was also announced that a support service worker had been appointed without the involvement of the Fletcherford planning group members. There was no dissent but there was never more than one service user at subsequent meetings. It was apparent that the real decision making processes were occurring outside of the planning groups.

Once the council accepted the proposals in the strategic manager's report in April 2001, the Working Group was invited to plan an event to publicise the introduction of the scheme. The strategic manager said that a 'low key' launch would be appropriate so the only matters left for discussion were the invitation list and venue. The minutes recorded:

'It was agreed that it was not appropriate to have a high profile launch as the scheme could be flooded with referrals which could potentially cause a bottle neck.' (May 2001)

The 'launch' of the Fletcherford direct payment scheme was held at a pleasant, accessible venue, and was well attended by a small invited audience of service users and carers, representatives of voluntary organisations and care managers. It was reported by a paragraph on page four of the council's own free quarterly newsletter. There was no press release to the local paper or other publicity.

From the introduction of the support service to the Working Group, the discussion at meetings was led by its manager. The small number who attended addressed their questions and concerns to her. She was perceived as the expert on direct payments who had been given the responsibility for developing the local scheme, although the decisions on key issues were made outside of the Working Group, usually within the social services senior management team. Her contributions were always couched in technical language. The focus of discussion was on the issues of contention (discussed below). These were issues on which members of the Working Group were in broad agreement and which they considered were obstructing the successful implementation of direct payments.

'There are small pockets of people going off making changes without coming to this group. The strategic manager and I are completely by-passed How can we explain this to service users, like J who put so much work in to the group?' Planning Manager 2, Working Group meeting, February 2002

Nevertheless even within the reduced Working Group the role and status of community representatives as full participants was not fully accepted. As the Support Service manager

commented to the Planning manager (2) at one meeting, which was attended by no users, carers or voluntary sector representatives:

'It's very useful discussing things without users and the voluntary sector. Can we meet outside the Working Group in future to be discuss things which could be quite inflammatory?' (Working Group meeting, December 2001)

This apparent denial of the 'expertise' and the value of the contribution of people who actually used community care services went unchallenged and presented a stark contrast to the experiences of disabled people 'participating' in policy –action at the national level (described under 7.1).

The Macville based service was awarded the contract to provide support to direct payment users in Fletcherford for another year from April 2002. At the final meeting of the Working Group in May 2002 it was agreed that the support service would take forward the responsibilities of developing direct payments in Fletcherford, although the support worker was still funded for just two days a week. Local organisations would not have the opportunity to compete in a tendering process for the contract for another year. At that meeting the planning manager 2 described how a nearby authority had been criticised by an S.S.I./ Audit Commission Joint Review because it had not involved users in the development of its direct payment scheme. Lack of user involvement was recognised as an issue in the minutes:

'[Planning manager 2] discussed with the group how to involve users and carers in direct payments. Initially service users and carers had attended the Working Group, however attendance has declined.

[The support service worker informed the meeting about]a group that had been established [in another town, to give] ... users, carers and personal assistants the opportunity to discuss issues regarding direct payments, and to meet with other people using this service.... This would be a way to involve service users and empower them to make choices and decisions.' (Minutes of Working Group meeting, May 2002)

The part time support service worker was therefore left with the task of 'involving users' in future by facilitating a 'peer support' group focused on individual problems.

7.5.4. Working Group members' accounts

7.5.4.1. 'Professionals'

Paid members of the Working Group (from social services and the voluntary sector) expressed disappointment at how little local people had been allowed to participate in the decision-making processes in the introduction of direct payments.

'The opportunity for users and voluntary sector to have an input at an early stage has been missed. It seems to miss the point of direct payments being about choice and control.' (U.V.O. representative May 2001)

'Decisions are made outside the Working Group, and disabled people are not involved in the private meetings. People do not see the point in coming. They think it is better to meet separately than be dominated by the professionals' (Carers' group representative)

The 'professional' participants had expected the group to be involved in the design of a support service to be developed locally and eventually to be involved in the appointment of the staff. They thought that local voluntary groups would be interested in running a direct payments support service.

'It is not just about the involvement of local people in developing or selecting a scheme, but the whole question of ownership. You know what Fletcherford people are like, if it is not local, they will not want it.' (Practitioner representative to the Working Group)

The Users' Voluntary Organisation representative was also disappointed that no attempt had been made to recruit a local disabled person as a direct payments support worker. The 'expertise' of disabled people appeared to merit their inclusion in consultations and as volunteers but not paid employment.

'There are plenty of very able disabled people who work for us on a voluntary basis. People with qualifications and experience, they are reliable, enthusiastic, committed... What did for me was when I mentioned the shortage of disabled parking at [the town hall] and I was told it was not necessary. Don't they have disabled people working there? There are fourteen thousand people with disabilities in the town..' (August 2001)

All the members of the Working Group said that the strategic manager, in her role as chair, had tried to keep the meetings relaxed and informal and to encourage users to participate. Nevertheless it seemed that not all users felt comfortable in the meetings held in the council chambers, for the convenience of town hall based staff.

'I noticed that one service user had a problem at the meeting and his personal assistant did not feel comfortable enough to take him out.' (U.V.O. representative, August 2001)

Working Group members appreciated that the early meetings had been introduced as a shared learning experience for all concerned. They had heard accounts from direct payment schemes in other areas and all had been able to ask questions. However they commented that the dynamics of the group had changed once the support service manager had begun to attend as the outside 'expert':

'Involving users and carers was well thought through to begin with. Suddenly she took over the process, she started talking over peoples' heads, too technical... The philosophy is good, getting people involved. It has got to be consistent and not just tokenism.' (Practitioner representative, August 2001)

'The language used is inappropriate when they talk about disabled people, 'weeding out' and 'cherry picking'. They seem to want a portfolio of 'perfect cases'. Most people will think they can not live up to that ideal.' (U.V.O. manager, August 2001)

7.5.4.2. Users and Carers

Users and carers gave their individual reasons why they had stopped attending the Working Group. They were unclear about the purpose of their participation and did not express opinions about how successful the group had been. They all said that they had come along to meetings at first without being clear what they could contribute but were keen to help. All had overcome practical obstacles to do so, either because of their own illness or disability or the needs of the person they cared for. Most users and carers had been interested in direct payments as a possible alternative to direct services for themselves and did not see themselves as representing a peer group. However they had eventually been 'put off' by the focus of discussion on procedural issues, internal to social services. The use of technical language by the support service manager had impressed them (most referred to how 'clever' she was) but made them feel that managing a direct payment would be too complicated. As individual users and carers came to the conclusion that direct payments were not an option they would choose, they could see no point in continuing to come to meetings. All but one thought that the Working Group was a forum for keeping them informed of decisions being made by the council, like the one day consultation events they had previously attended. They did not think that they had any input to the decision making process.

Only one user continued to attend the Working Group. He considered that he had wider responsibilities, both to comment on the detailed proposals for the scheme and to share information with day service users and staff. He was one of the first people in Fletcherford to request a direct payment and had initially hoped to collaborate with others, service users, staff and voluntary groups, to develop and run a support service. However as the meetings progressed he became increasingly worried about the responsibilities involved in getting a direct payment, the lack of flexibility in the systems discussed and the technical language used. *'I felt I was on the edge of a precipice'* (Interview, July 2001). He was also concerned to hear that a request for a direct payment would automatically require a re-assessment. He stressed that this would be an unwelcome ordeal: *'Why would I need another assessment? My needs have not changed.'* (Working Group meeting, February 2001). He therefore withdrew his own request for a direct payment in May 2001, but continued to attend Working Group meetings to represent day services, until November 2001.

Ironically some disabled people were unable to attend Working Group because of the inflexibility of their personal assistance and transport arrangements, the very reasons why they recognised the potential of direct payments to facilitate their 'inclusion' in normal life.

'Getting to the working group meeting is very difficult. I cannot just have a lift off anyone because my wheelchair has to be folded.. ... I need someone to come to the door to collect me. Taxis just wait outside' [User, who attended two Working Group meetings]

'I think direct payments are a good thing. I would like to be on the committee. I have got so much experience of services. I am sorry I have missed so many meetings.... it is difficult fitting in with my care hours. I do not often go out but when I do something goes wrong. The yellow taxis are not really wide enough for my sort of chair.' (User, who attended two Working Group meetings)

Another user dropped out of the Working Group for a mixture of reasons;

'I used to be vice chair of the 'Users' [voluntary organisation], but I gave it up after I was mugged twice in my chair. I am nervous going out. Not everybody understands the way I speak if they do not know me. I am not sure it is worth the effort if they are not going to listen to what I say. ...I am not sure what the meetings are for' (User who attended one Working Group meeting.)

7.6. Perspectives on the selection of the support service

The Principal Contracts Manager explained, in interview, the decision to commission a service from another area, instead of developing a local scheme or contracting with a local organisation. It was to save time and money on specifying (designing) and tendering for the service, although the council was not obliged to use a competitive process. He also explained that the Working Group could not be consulted on the appointment of a support worker because he was recruited before the council had given its official approval to the proposal. The manager had confidence to appoint before 'official' confirmation that the contract would be awarded; this demonstrated that it was senior officers' rather than politicians who were making key decisions at the time.

The Principal Contract Manager did not join the authority until November 2000 and had limited local knowledge. However he advised me with confidence that there was not a local voluntary organisation that would have been interested in providing the support service to direct payment users in Fletcherford. Others on the Working Group did not share his opinion;

'Local voluntary organisations would be interested in running the scheme. A lot of us are gearing up for contracting. We want more involvement and we are a friendly face people can relate to. ...Funding is important, we want to secure our future.' (Users Voluntary Organisation representative May 2001)

The practitioner representative agreed:

'I do not know why they thought the voluntary sector would not be interested, they came to nearly every meeting and everyone knows them.' (August, 2001)

The Voluntary Sector Development Agency, funded by Fletcherford council, had not been approached by social services with a view to establishing whether there was potential for the development of a local support service. He explained that social services was dominated by a culture of contracting for services to meet measurable performance objectives and not concerned with wider policy objectives of community development and participation.

'The government is promoting participation and inclusion but...social services look in terms of contracts... they have no concept of capacity building. There is no-one in there

with a community development focussocial services are preoccupied with their own agenda and what they have to do for performance measurement....' (Senior manager in the local voluntary sector development agency)

This was one of several examples of the use of centralised performance management devices by the government, intended to secure compliance with its policy reforms, that instead diverted attention from ultimate policy objectives or outcomes to short term intermediate 'outputs'.

7.7. Obstruction and Delaying Tactics in the Planning Stage of Implementation

Contracts staff in social services and the council's principal solicitor were opposed to direct payments. They were unable to resist the 'top down' pressure from central government to implement the initiative in Fletcherford. However they were able to influence key decisions in the planning process that would restrict the potential benefits of getting direct payments, and ensure they were unattractive to many users. The efforts of those opposed to direct payments threatened to undermine the ultimate objectives of government policy on direct payments, because those with the potential power and knowledge to overcome this opposition (senior operational managers) were pre-occupied with other work demands.

Two contentious issues that were decided outside of the planning groups were presented in the director's report to the council, on April 2nd 2001. They were the amount users' would receive as a direct payment, in lieu of services, and the services for which direct payments could be made as an alternative. Other contentious issues were the Letter of Agreement and Capacity.

7.7.1. The hourly rate

Working Group members, apart from contracts officers, had consistently argued that users should receive direct payments at an equivalent or higher rate to the prices the council paid independent sector agencies. They also maintained that direct payment rates should be index linked to the 'agency rate', to reassure users that they would not be eroded by inflation. The practitioners surveyed in 2000 had identified that an inadequate rate would deter people from requesting direct payments. Most Working Group members argued that users as individual employers would be unable to recruit skilled and motivated staff unless they could offer competitive rates. They also asserted that users should have the option of using agencies rather than employing their own staff if they chose. There was general agreement that many potential users would be reassured if they could afford to buy agency relief staff in an emergency. Individual users also said that they wanted to pay their personal assistants a 'fair wage'.

The strategic manager, who chaired the meetings, encouraged members to air their opinions and said in interview that she understood their concerns. Operational managers generally disagreed with the idea that the council should save money through paying users less than the 'market prices' they paid agencies. Nevertheless the decision was made outside the planning groups to

make direct payments at a lower rate than agency contract prices. The strategic manager explained that the head of contracting had successfully argued in the social services management team that users did not have the same expenses as agencies.

This user's view was different:

'My aim is to make the payment rate attractive for people I am going to employ. I need people with administrative and care skills. Users will have to pay the rate to get the staff' (User representative, December 2000)

A year later this issue was still not resolved despite the continued efforts of the second planning manager to influence the senior management team. When the agency rate was increased with inflation the following April (2002) a further struggle ensued. The strategic manager's arguments secured an increase in the direct payment rate but not automatic index-linked increases in future years. Resistance continued from the contract team, whose influence seemed to be bolstered by their alliance with the solicitor and by their technical knowledge, which was not shared by managers with social work backgrounds (including the director). The contracts manager had virtually no experience of working with community care service users or knowledge of the disability rights/ independent living movement. However he felt able to explain confidently why direct payment users should not be empowered to buy services from agencies in the local community care market.

'Direct payments are supposed to be about users employing their own staff, not buying from agencies.' (Contracts manager, April 2001)

This comment was an example of how actors defined or prioritised policy objectives to suit their particular interests or ideological positions.

7.7.2. Approval only for personal care

The report that was approved by the council in April 2001 proposed the introduction of direct payments for personal assistance only at a single hourly rate. The Strategic Manager explained that she wanted to keep the scheme simple to start with, to avoid deterring staff, users or politicians with complicated financial formulae. *'We need to start small and develop slowly'*. (February 2001) She responded to questions from operational managers about the potential problems for users with greater needs who require a complex package of services.

'This a very simple basic scheme, we want to get a few people through. I do not want to say guinea pigs, brave people. Trail blazers' Strategic manager

'You mean you are going to cherry pick?' Joint planning manager
(Observation of meeting of the Care Management Unit Management Team, February 2001)

However this meant that there was no approval of direct payments for service users who wanted to change their arrangements for day care or respite, or for carers who wanted cash instead of the 'sitter service'. The system was therefore set up to facilitate the employment of personal assistants, not alternatives potentially more attractive to users worried about the responsibilities of being an employer. The latest available guidance said:

'Councils should ensure that commissioning arrangements are consistent with the objective of promoting direct payments... Moreover, councils should prevent inflexible internal budget management procedures from hindering the commencement of a direct payments package.' (Fair Access to Care Guidance, draft published in 2001, page 6, paragraph 27)

Irrespective of this, the influence of the contracting staff meant that individuals were not given the purchasing power to make choices consistent with market theory. The pragmatic use of the market advocated in the 'third way' (Dept. of Health 1998a) was thus obstructed for direct payment users.

7.7.3. The Letter of Agreement

The solicitor's official role in implementation was to approve the wording of the 'Letter of Agreement', the contract between the council and individuals receiving direct payments. The process of producing this document began with a draft, developed on the advice of the National Centre for Independent Living. This document was then passed between senior managers in social services and the solicitor until a 'final' version was agreed. It was presented to the amalgamated planning group for 'approval' in September 2001, six months after the target start date for the scheme. The document was subsequently revised twice more on the initiative of both the director of social services and the solicitor. Each time the conditions attached to receiving a direct payment became more specific. Each time the agreement was altered no new direct payments could be made until the revisions had the solicitor's approval.

The government's intention was that direct payments should be an alternative method of arranging care packages, based on a care manager's assessment of need and a care plan agreed with the user.

'Direct payments are a different way of fulfilling existing community care responsibilities...' (Dept. of Health 2000, 3, para. 3)

The usual process for arranging a community care package in Fletcherford required the practitioner to write the care plan and obtain the approval/ signature of her own manager (two steps). The process agreed for approving a care plan involving a direct payment had eight steps and included the signature of the director of social services on the Letter of Agreement. This was the source of frustration to the Planning and Team Managers, who found it hard to justify to practitioners. The (depleted) Working Group members were also aware that these complications

would obstruct the growth of the scheme but were told by senior management that it was 'not negotiable'.

'Any straightforward case will probably find its way through the system. But anything unusual will get blocked because of lack of understanding at each point.' Support Service Manager, December 2001

As early as May 2001 the representative of the Users' Voluntary Organisation expressed her own concerns that if the process of accessing direct payments was made too tortuous many potential users would be deterred:

'If people are having problems with their current care they will put up with the hassle, but otherwise they see it as too difficult to get onto direct payments.' (U.V.O. representative, in interview May 2001)

By December 2001, three people were receiving direct payments but approval of new payments was suspended, until the solicitor agreed the latest amendments to the Letter of Agreement. The director also required the inclusion of a detailed care plan before she would authorise the first payment. This did not seem to be in keeping with the spirit of the latest guidance:

'Local authorities should seek to leave as much choice as possible in the hands of the individual, and allow people to address their own needs in innovative ways, whilst satisfying themselves that the person's needs are being met...' (Dept. of Health 2000, 4, para. 6)

Working Group members could not understand why the director wanted highly specified care plans:

'I thought the idea was to give user control, flexibility choices over how they use the hours. If they are not getting the choice and control, why go for the hassle of direct payments?' (U.V.O. representative May 2001)

The quote above from the 'Fair Access to Care' guidance suggests that the government sought to use this policy initiative to support the development of direct payments. However the issue of 'equity' as presented in the draft guidance was also used to explain how direct payment users choices had to be restricted to ensure that they could not enjoy an advantage over direct service users.

'It is not fair if people who get direct payments can get things that other users can not' Strategic manager (May 2001)

This was another example of how within a complex policy programme, actors can select particular objectives to suit their own personal or ideological perspectives. Here the manager prioritised the policy objective of equality of outcomes over equality of opportunity, cost effective use of resources or user control. Thus the strategic manager was amongst those who seemed to expect that users would be willing to endure a lengthy process to access direct

payments and accept the additional responsibilities involved, without enjoying any practical advantage.

7.7.4 Capacity

The common law in England and Wales presumes capacity. The New Labour government's guidance said that local authorities were not to '*fetter their discretion*' by making assumptions about the appropriateness of direct payments for whole groups of service users (Dept of Health 2000a). Individual applications were to be judged on their merits.

Community care assessments were usually carried out by practitioners and automatically endorsed by the council. The 2000 guidance also said that councils should assess whether users were capable of managing direct payments '*with assistance*'. (Dept of Health 2000a). This was intended to stop councils raising capacity issues to prevent people with intellectual impairments from getting direct payments. The government had shown its commitment to enabling people with learning disabilities to get direct payments by producing the '*Easy Guide*' in collaboration with a group of service users, with picture based and audio materials. The government also published a White Paper '*Valuing People*' (Dept of Health 2001) which proposed a national strategy for learning disability services. The aims were to promote choice, control and independence for people with learning disabilities. Performance targets for local authorities were included and embraced enthusiastically in Fletcherford by care management staff and the multi agency planning group (a forum including users, carers, health and the voluntary sector). A target of enabling three people with learning disabilities to access direct payments in the following year, was quickly included in Fletcherford's '*Valuing People*' Implementation Plan.

One young man requested a direct payment in June 2001. His social worker successfully progressed an application for a direct payment from the Independent Living fund. Unfortunately he could not sign his name (his father normally signed on his behalf) and so could not sign the 'Letter of Agreement' to receive a direct payment from social services. The contract team therefore referred the matter to the solicitor, who refused to allow a direct payment. Six months later the matter was not resolved and practitioners working with people with learning disabilities were reluctant to raise the expectations of their clients by offering direct payments. The influence of a 'care discourse' (Morris 1993) over the actions of key council staff and their interpretation of policy guidance was evident. Thus as the social services staff explained at the Working Group meeting of December 2001:

'The current state of play in (Fletcherford) is that no-one with a capacity issue can get a direct payments' Contracts manager

'[the solicitor] said "would you allow a six year old child to be an employer", She is determined no-one with a learning disability will get a direct payment' Planning manager

The minutes of this meeting recorded;

'2.2 The legal department ...has refused to allow individuals who do not understand the full implications of a direct payment i.e. employment law, insurance, employer responsibilities and the full implications of the legal agreement, to access direct payments.

2.3 Social services has made the commitment to challenge this decision, on the basis that people who access direct payments do not need to have a full understanding of employment law, insurance etc as there is a support service that will support and assist people in managing their their direct payment.' December 2001

Nevertheless by the Working Group meeting of May 2002, the minutes addressed the issues of people with learning disabilities accessing direct payments under Any Other Business;

'At present there has been no change, and the issue continues to be a challenge'

The solicitor could not prevent disabled people generally from getting a direct payment in Fletcherford, in the face of strong support for the initiative from central government. However she interpreted the guidance (Dept of Health 2000a) to obstruct access for people with learning disabilities. She chose to prioritise the council's obligation to assess capacity over the government's later policy statements in *'Valuing People'*, which included the objective of increasing the numbers of people with learning disabilities receiving direct payments (Dept of Health 2001d).

7.8. Discussion

The first planning manager's aspirations for user participation in the implementation of this particular initiative began at the level of the second top rung of Arnstein's ladder of power-sharing¹⁹, with community representatives on the Working Group being given *'delegated power'* to develop a local support service. She hoped participation in the development of the scheme as a whole would be at the level of *'partnership'* with dialogue between the Reference and the Working groups on the development of internal systems required for direct payments. Two years later at the end of the 'planning process', the second planning manager's aspirations for user participation were far more modest than her predecessor's had been. Outside 'experts' contracted in to Fletcherford to provide support to users were left to take forward the task of developing the direct payment scheme. The part time support worker was given responsibility for facilitating a 'peer support' group. In terms of Arnstein's (1971) ladder of power sharing, the aims of involvement had sunk to the second bottom rung, to the level of *'therapy'*.

In 2000 the first planning manager recognised that direct payments were not only a means to the ends of enhancing user choice and control; if users were involved in their implementation they

¹⁹ *The rungs on the ladder descend from citizen control through delegated power, partnership, placation, consultation information and therapy to manipulation*

had the potential to contribute to the achievement of other policy objectives. She thus demonstrated the 'joined up thinking' advocated by the Blair government in its policy directives. However once she left, the pressure to demonstrate progress in the achievement of centralised performance indicators supported a focus by social service senior management on the narrow, intermediate objective of having a 'simple, basic' direct payment scheme in place. This narrow focus was to the detriment of the ultimate objectives of the central government's policy reform including promoting 'independence' in its widest sense.

Access, transport problems and inflexible support were obstacles to the involvement of some users in policy implementation processes in Fletcherford. These were anticipated by the first planning manager whose efforts initially encouraged users to struggle to overcome these barriers to contribute to the introduction of an initiative with potential benefits they recognised. Most users who volunteered to participate believed they had knowledge from their experience of using services but did not know how it could be used to contribute to the development of direct payments. The introduction of the professional expertise of the support service left users and carers feeling intimidated by the use of technical terminology and superfluous. It undermined the official remit of the Working Group, which was to research and develop an appropriate model of support. As the purpose of the meetings became increasingly unclear, the practical barriers to participation became insurmountable for most users.

A danger in the movement for greater user involvement was identified by Brandon (2002, 17) as the drift towards the '*dictatorship of the articulate*'. One user representative on the planning groups fitted the perception of the 'ideal' disabled participant. He was white, with a professional background (Ali and colleagues 2001) used a wheelchair and had no labelled mental illness or impairment (Brandon and Brandon 2002). His 'expertise' was widely respected in the local 'care' community, amongst users, carers and public and independent sector practitioners. Nevertheless in the planning forums, supposedly established to 'involve' users in the development of the scheme, the superior authority of the solicitor was '*taken for granted*' (Schutz 1972), while the well informed opinions of users and carers barely influenced the content of meetings nor ultimately the outcomes of decision making process. Greener's (2002) use of the concept of 'habitus' to explain the barriers to service users acting as 'reflexive' or 'active' citizens is relevant here, particularly to the power of the solicitor as the holder of the 'social capital' of her professional status. Experience in this case study suggested that the barriers to meaningful participation by those service users Brandon (2002,18) argued were vulnerable, marginalised and often forgotten within the disability rights movement itself, including '*mental health survivors and people with learning difficulties*' were even greater.

This case study also revealed how lack of coherence in the crafting of policy can, as Meier and Mc Farlane (1996) asserted, undermine the objectives of policy making through lack of clear

direction in implementation. Key actors who were opposed to the introduction of direct payments in Fletcherford were able to exploit ambiguities in policy guidance with the aim of diluting or negating the effectiveness of the initiative. The solicitor had been open in her opposition to the principle of giving individuals care budgets and control over purchasing decisions. Her objections had been framed in terms of users' vulnerability to exploitation, their inexperience in managing money, their unsuitability to be good employers and that local people were against the proposal. She failed to produce any evidence to support her contentions, however as the senior 'expert' involved in implementation the onus was not on her to do so. In contrast others with more relevant expertise were continually challenged and were required to produce evidence in support of any argument they made to improve the direct payment scheme, in terms of access and benefits for users.

The contracts managers did not overtly oppose the idea of direct payments in principle, but instead questioned why the council was investing any resources into an initiative that it was not statutorily obliged to implement. They colluded with the solicitor to obstruct progress on the issues of Capacity and the Letter of Agreement. They were also able to exploit the interest of some senior managers in keeping the scheme 'simple' and easy to contain, by endeavouring to ensure direct payments were made conditional upon the users' willingness to take on the responsibilities of being an employer. Other managers who were broadly in favour of direct payments did not have the time to give the initiative their full attention and support during the planning stage, because of the pressures of the wider policy reform programme, re-organisation and staff turnover. The complexity and scope of the whole '*modernisation*' programme and its interaction with the continuing development of community care, meant that individual actors could prioritise particular policy objectives to suit their own professional, personal or ideological ends.

The findings presented next will demonstrate how issues that were unresolved during the planning stage, together with the potential obstacles to the success of direct payments identified in the practitioners' survey in 2000, affected the experiences of individual users, carers and practitioners during implementation.

CHAPTER EIGHT

Direct Payments: Potential and Performance

'Direct payments are a means to an end and that end is independent living. We need to hang on to that. Direct payments are not a good thing or a bad thing in themselves. Direct payments are just a way of getting to independent living' Hasler (1999, 6)

8.0 Introduction

The accounts of the actors involved in the early implementation of direct payments in Fletcherford, and the observations of those who advised them, are discussed next. They reveal that decisions made in developing the local scheme, against the opinions expressed by the practitioners' surveyed and most planning group members, limited the benefits and 'take up' of direct payments. They also suggest that many people wanted choice, control and flexibility in their care arrangements without additional responsibility, because of their personal circumstances and past experiences. The actions of community care service users were influenced by social justice considerations, rather than simple self-interest or 'instrumental rationality'. The initial enthusiasm of practitioners for direct payments expressed in 2000 had waned a little by 2002, along with their support for New Labour's approach to policy implementation. The importance of the role of care managers as 'street level bureaucrats' was confirmed.

The annual review of the social services performance for 2001 to 2002, suggested that the introduction of direct payments in Fletcherford was regarded as an example of achievement in the pursuit of policy objectives:

'Strengths and Improvements during the year.....Activity on direct payments has improved with 30 enquiries leading to 6 people actively benefiting at the time of our meeting.' Letter to director, 4th April 2002 from Regional Inspector (Performance)

Compared to other authorities, the direct payment scheme in Fletcherford was successful, if measured by the number of users recruited in the first year of implementation. However the findings presented next show that much of the potential of the initiative, advanced by the disability rights movement, promoted by the government and reflected in the early expectations of practitioners, was not realised. Where positive outcomes were secured this was due to the courage and tenacity of a few community care users and the determination of some practitioners to use their relationships and discretion to improve the care arrangements and quality of life of their clients.

8.1 Data

The findings presented here are based on the following:

Table 8.1. *Data sources and relevance to policy-action process*

<u>Source</u>	<u>Contribution</u>	<u>Method</u>
Dept. of Health civil servants	Guidance on implementation issues	Telephone conversations between February 2000 and June 2001
32 Care managers	Community care assessments + care plans	Survey : semi-structured interviews, October to December 2001
22 community care users + carers	Expressed an interest in direct payments	Interviews, June 2000 to January 2002 [see tables 8.2 to 8.5 below]
Social workers	Received requests for direct payments	Interviews, observations and conversations June 2000 to Feb.2002
Team managers	Supervised practitioners	Interviews, conversations and observations. Sept. 2000 to Feb.2002
Strategic manager	Chaired planning groups.	Interviews, conversations and observations .Feb. 2000 to 2002
Lead operational manager	Supported practitioners in the implementation of direct payments	Interviews, conversations + observations . October 2000 to February 02
The support service manager	Represented the support service to council leaders and managers.	Conversations and observations at meetings. January 2001 to May 02
The support service worker	Supported individuals requesting direct payments.	Interviews, conversations and observations . June 2001 to May 2002
Age Concern regional manager	Represented + advocated for older people	Interview. May 2001
Sheltered Housing Wardens	Supported tenants and liaised with health + social care services	Group discussions. February 2001
Performance measures and Dept. of Health monitoring returns	Official indicators of achievement of national policy objectives	Analysis of figures and discussion with management information team. April to August 2001

8.1.1. Practitioners' survey

Care management practitioners shared their impressions and experiences of the introduction of direct payments. They were also invited to comment on their experiences of policy change and in particular the implementation of 'Modernising Social Services' (Dept.of Health 1998a).

8.1.2 Interviews with community care service users

Between April 2000 and February 2002 twenty-five enquiries about direct payments were recorded, including one that was inappropriate. Six came from households with two service users, so a total of nineteen families made an enquiry. I interviewed representatives of seventeen of the households. I was asked by the respective care managers not to contact the other two people, one was in hospital and the other had been refused a direct payment on legal advice.

Eight enquiries were made in the first year of implementation (before April 2001). I interviewed five people twice about their expectations and experiences of direct payment and one person

three times (see tables 8.2 to 8.5). The first enquiry came from an older couple in March 2000. I interviewed them first with their daughter. The husband died in November 2001 and, at the family's request, I interviewed their daughter only in January 2002.

All the users and carers I contacted contributed to my research because they hoped that sharing their knowledge and experiences could help other people somehow, whether or not they decided to pursue the direct payment 'option'. Those who contributed included people who had been recently bereaved, who were ill and in pain, in unhappy social circumstances and one lady who was terminally ill, who talked to me just weeks before her death. In terms of their willingness to give their time and expertise to the benefit of the wider community, they were fulfilling their civic duties in the Aristotilean sense, as distinguished by Jordan (1999).

8.2 Progress and 'Performance'

In the year to 2001 Fletcherford council provided non-residential social care services to 6706 adults. In reporting performance against policy objectives, people provided only with disability aids were included to boost the numbers of people 'helped to live at home' from 1999. The manipulation of information by senior managers, to demonstrate satisfactory performance, and by practitioners to improve care arrangements for their clients, was a recurring theme and other examples will follow. Nevertheless all 6706 social care users were potentially eligible to ask for a direct payment.

The 'success' of Fletcherford council in recruiting six people to its direct payment scheme might be re-considered in this context.

8.2.1 Interest from Users

Fletcherford council made the first direct payments in October 2001 to two people. By February 2002 five people had received a direct payment, including one who had also begun to receive payments through the Independent Living Fund. Four had waited over a year from their first enquiry. Another five of the original twenty-four had successfully applied for ILF payments and ten people had withdrawn their interest. Therefore of twenty-five enquiries to Fletcherford council, only five had resulted in a direct payment by February 2002. However six enquiries resulted in a successful application, by the care manager, for a 'direct payment' from the Independent Living Fund, even though the eligibility criteria were in principle much stricter than for a council direct payment. Twelve households did not have a user who met the eligibility criteria for an ILF payment²⁰. The other person was already receiving ILF.

²⁰Under 65 and in receipt of the Disability Living Allowance for care at the highest rate

Table 8.2 Users receiving direct payments by February 2002

Informants	No. of users in house hold	User group	Interview dates	ILF	Outcome	How did they hear about direct payments?	Comments
U1a+b +C2 Couple, over 80 and daughter Eligible carer.	2	Older people	5-03-01 10-01-02	Ineligible (over 65)	1 st request April 2000. Letter to director 1 st Feb. 2001. 1 st payment October 2001	From their daughter who worked for another social services department.	Couple had run a business and daughter is a care professional. Met personal assistants through agencies.
U3 a+b Couple	2	Terminal illness and carer with mental health problems	19-03-01 16-01-02	Ineligible because of terminal illness	1st request October 2000, complaint letter 5 th July 2001. 1 st payment December 2001.	From Carers' Organisation	Payment to user only. Couple had run a business. Met personal assistants through an agency and voluntary organisation
U2 Man lives with wife and daughter (not interviewed). Eligible carer.	1	Physical disability	19-12-00 11-05-01 7-12-01	Granted Also health funding	1st request June 2000, withdrew May 2001, reapplied November 2001, 1 st payment Feb 2002	From 1997 consultation and the Internet.	Experience of managing staff and PAYE. Met personal assistants through agencies.
U14 Single woman	1	Physical disability	16-01-02	Ineligible (not D.L.A. higher rate)	1 st request October 2001, 1st payment December 2001. Formal Complaint Pending.	From 'Epilepsy Outlook' voluntary group.	Experience of service management and two daughters working in finance. Met personal assistant through an agency
Total recorded	6						

Table 8.3 Applications in process in February 2002

Informants	No. of users in House hold	User group	Interview dates	ILF	Outcome	How did they hear about direct payments?	Comments
U4 Lady over 80, lives alone	1	Older person + illness	18-12-01	Ineligible (over 65)	In process 1st enquiry August 2001.	From care manager.	Awaiting more information Met personal assistant through an agency
U13 + C3 86 year old man living with his daughter (interviewed). Eligible carer.	1	Older person with a physical disability	15-01-02	Ineligible (over 65)	In process.. 2 nd Application September 2001.	From a friend working in a direct payment scheme in another area	Awaiting management decisions, Considering employing friend, who works for an agency. 1st enquired in April 2001 but withdrew. Reapplied because urgent need for help while carer has surgery.
Total Recorded	2						

Table 8.4 'Abortive' Enquiries and withdrawn applications by February 2002

Informants	No. of users in House hold	User group	Interview dates	ILF	Outcome	How did they hear about direct payments?	Comments
U7 Single woman living alone	1	Physical disability	20-06-00 15-03-01	Granted	1 st enquiry June 2000. Withdrew request due to worries: cover +rate	From Users' Voluntary Organisation.	Met p.a.s through agencies
U9a+b : Couple, wife under sixty five	2	Physical disability and blind	25-07-00 8-02-01	Granted	1st enquiry in June 2000. Uncertainty, resolved problems while waiting.	From the Blind Welfare Association	Met p.a.s through agencies.
U5a+b : Couple both aged over 80	2	Older people + disability	11-04-01	Ineligible (over 65)	1st enquiry March 2001. Worries cover + low rate	From Carers' Voluntary Organisation	Met p.a.s through agencies
U16 + C1 Woman living with husband. Eligible carer.	1	Physical disability	08-08-00 02-04-01	Granted	1 st enquiry August 2000. Rate too low	From Carer's Voluntary Organisation	Met p.a. though agency. Now paid by ILF.
U17. Woman living with husband Eligible carer	1	Physical disability, over 65	30-4-01	Ineligible (over 65)	1st enquiry April 2001. Not for equipment	From Care manager	Ineligible for personal care due to SSD charges
U12. Single woman, living alone	1	Physical disability	4-01-02	In receipt	1st enquiry September 2001. Too much worry	From Users' Representative on Planning Group.	Mixed package. Met p.a.s through agencies
U10 Woman living with husband . Eligible carer.	1	Physical disability	11-01-01	Ineligible (Low DLA.)	1st enquiry November 2001. Will wait +see	From Users' Representative on Planning Group.	
U11: Woman living with husband. Eligible carer.	1	Older person +disability	11-01-02	Ineligible (over 65)	1st enquiry November 2001. Will wait +see	From Users' Rep. on Planning Group.	
Total	10						

Table 8.5 Outcome of direct payment applications still undecided

Informants	Users in House hold	User group	Interview dates	ILF	Progress by February 2002	How did they hear about direct payments?	Comments
U15 Woman living with husband and 12 year old son. Eligible carer	1	Physically disabled parent of learning disabled child who is also a carer	12-07-01	Ineligible (middle D.L.A.)	1st enquiry June 200 User still undecided	From Users' Voluntary Organisation	Lack of information and guidance
U8a+b Mother and daughter with constant care needs	2	Physical disability	7-2-01 15-01-02	Granted	1st enquiry January 2001. User still undecided	From care manager	Worried rate too low. Met personal assistant through agency, now employing her using ILF paid at top agency rate
U6 Single man over seventy	1	Older person , blind.	20-03-01	Ineligible (over 65)	1 st enquiry March 2001. User awaiting more info and guidance in braille	From Blind Welfare Association	No prospective employee identified
U19 Young man living with his single parent father Eligible carer	1	Learning disability	Not interview	Granted	1st applied June 2001. Refused due to capacity issue. Care manager + Planning Manager still trying to resolve capacity issue.	From care manager.	Met personal assistants through agency, now employing her using ILF. No further applications from LD team while unresolved
U18 Single woman	1	Mental health problems	No interview	Ineligible (Middle D.L.A.)	1st request September 2001	From mental health service users' group.	Application suspended during hospital admission, will re-activate on discharge
Total	6						

8.2.2. Carers

From the nineteen households, I identified nine carers eligible to apply for direct payments in their own right and interviewed three of them. Their concerns were about securing a direct payment to meet the user's needs and they did not distinguish their own needs for support in caring. The care managers realised that these carers were entitled to support, but their efforts were concentrated on achieving direct payments for users because the council had not yet agreed a system for making payments to carers.

The named clients cared for each other in three of the two user households. In two cases the second user (an elderly spouse) was in reality the main carer but had been assessed as a user by their care manager. Interviews revealed that this was a common practice amongst care managers to circumvent the 'ceilings' placed on the cost of care packages for older people, set at the net cost of residential care. In contrast care managers were encouraged to 'cost up' care packages funded by the council for under 65s to the £200 weekly threshold, for eligibility to additional funding from the Independent Living Fund. Therefore in households with two users where one person met the criteria for extra funding from the ILF, the social services contribution to the care package was loaded towards the eligible person. Amongst those enquiring about direct payments, this was achieved for two of the two user households (8 and 9).

8.2.3. Discussion

The 100% success rate achieved in securing ILF payments, where potentially available, suggests that the failure of most of the initial enquiries to lead to a direct payment was not due to a lack of interest or effort from care managers in Fletcherford. The manipulation of information on service costs and individual needs revealed that practitioners used their discretionary power and privileged insight into the circumstances of individuals and households to achieve the outcomes their citizen/clients desired.

8.3 Expectations from the 2000 Practitioners' Survey

In the 2000 survey fifty-four practitioners' said that they had known people who could have benefited from direct payments and forty-six said that direct payments would benefit more than 'a few' service users. The Fletcherford scheme gained the council's approval in April 2001 by which time eight requests for direct payments had already been recorded. Nevertheless by February 2002 only twenty-five enquiries were recorded and by April only thirty. Most practitioners surveyed in 2000 suggested that lack of general awareness about direct payments would be the major obstacle to the expansion of the scheme beyond a few well-informed users in Fletcherford (6.4 and 6.5). This reason was also often given by practitioners for the lack of 'bottom up' pressure for the introduction

of the initiative locally. The 2000 survey data was circulated to the planning groups and managers responsible for the implementation of direct payments. Nevertheless those leading the process deliberately opted for a 'low key' approach to publicising and launching the scheme, which may explain the low level of expressions of interest.

The accounts discussed in this chapter reveal that three other issues identified by the practitioners in the 2000 survey proved to be relevant to the apparently high 'drop out' rate amongst users enquiring about direct payments (table 6.32). 'Uncertainty', was realised in lack of reassuring answers to users' questions and lack of clear procedures for practitioners to follow. Uncertainty delayed users' access to direct payments and made practitioners reluctant to promote them. 'Fear of change' was identified and usually related to 'uncertainty'. 'Worries about being an employer' were also correctly foreseen. Practitioners suggested that some users would prefer direct payments at rates commensurate with market prices to enable them to buy directly from agencies or pay for services other than just personal care. This was borne out in experience. However the payment rate was one of the contentious issues that the planning group responsible for the implementation of direct payments in Fletcherford had not resolved.

8.4 Practitioners and the Policy and Organisational Context

Experiences of the introduction of direct payments can be understood in the context of the care managers' whole situation. Practitioners were engaged in the process of implementing New Labour's policy programme through interactions with managers, colleagues in other agencies and individual citizens, along with responding to the routine demands of community care. They were invited to elaborate on their experiences of community care, *Modernising Social Services* as well as direct payments. In 2001, they were generally more critical of the impact on users of New Labour's policy programme. Practitioners described an acceleration of the move away from relationships with users because of the pressure to achieve a 'turnover' of cases in pursuit of performance indicators, they often perceived as irrelevant. They described frustration with the impact of policy changes on their workload and their ability to provide a good service.

'Modernising Social Services has created loads of work for senior managers and they try to pass it on. The government is setting the agenda and we are told to implement it, but we are the ones trying to put the theory into practice.' PR.11

'The paper work is increasing. We have little time to spend with people, little job satisfaction.. We hear National Service Framework, but what we hear on the ground is that people are not happy.' PR.14

' [There is] less time with service users, more forms, more deadlines, more accountability.... but no more money. There are tick boxes for when we get inspected but people themselves are getting pushed to the back of the queue. ' PR.25

Only one practitioner in discussing his frustrations mentioned his personal interests, explaining why he dare not protest about poor services. He identified possible benefits for himself and service users in the move to integration with health services:

'... I swallow my frustration because of my career... I would rather go to the Care Trust, better perks and better support, managers are willing to get involved and to see users. There is a better public perception of health staff' PR.11

One practitioner (PR.16) described herself as a 'fatalistic subversive', explaining how she felt obliged to accept the broad parameters and direction of policy change, but worked within them to get the best arrangements she could for her clients.

8.5. Motivation, Why People Were Interested in Direct Payments

All informants emphasised the importance of relationships and reciprocity between users and care workers. Resistance to the 'commodification' of care through the mixed economy, identified by Dwyer (1998), was a significant aspect of the general support for direct payments.

Users and carers complained about the failure of agencies to ensure continuity in staff, compatibility with individuals and competence to meet their particular needs.

'Before my parents got a direct payment, social services contracted for care from an independent agency. They had five different carers in one week. People turned up that my mother had never met. They were often unreliable.Too much variation in competence and attitude. ' Carer 2

The trust that develops in relationships was vital to users who saw themselves as vulnerable:

'It is very important for a blind person to have a regular worker ... Now they send anybody, that is no good, you could be robbed. It is no good saying that they are vetted. ' User 6

'I am thinking about employing a girl who used to come to me through the agency. She does not work for them anymore but she still visits me and helps me. I trust her and I know she is reliable. I am eighty three and poorly with cancer. ' User 4

Practitioners also talked about 'trust', for example:

'The biggest thing people complain about [agencies] is changes in home care staff, they are unreliable... they are expected to entrust their physical care to these people. We also seem to be getting an increase in allegations of petty theft. ' PR. 32

This was significant given that one of the reservations some senior council staff had about direct payments was that they could leave people vulnerable to abuse and exploitation.

Practitioners echoed the criticisms made in 2000 about the effect on the quality of care of 'privatisation'. They were disillusioned that the raised standards promised by New Labour (Dept of Health 1998a) had yet to materialise:

'There is still too much difference between social services home care standards and the independent sector, that is the feedback from health, district nurses and service users... There are still agency girls turning up without protective clothing, basic hygiene around food preparation and personal care is lacking. PR. 26

However blame was not confined to the legacy of past Conservative governments. Practitioners in 2001 criticised the poor training and supervision of agency staff, which they attributed to inadequate public funding as well as the profit motives of private providers.

'There are problems with independent sector home care. ... They can not offer enough to retain staff or to get them qualified.' PR. 18

'Policy changes are making life more difficult for managers but not necessarily improving the service for users. The quality of staff is the issue, sometimes you think that they are just dragging them in off the street. But the department does not pay enough money for them to attract the right people. PR. 27

'It is all about money and profit and keeping costs down. Social services decision makers are not effected by services being so poor, it is the users who suffer while the local authority saves money.' PR.28

Concern about the working conditions of people employed outside the public sector was common and was remarked upon by the co-director of the NCIL who led seminars promoting direct payments in the north (June 2001). However this interest in the welfare of others was not limited to practitioners. Next to being able to choose their personal assistants, the most common reason expressed by users for their interest in direct payments was their desire to make life better for their staff:

'It was me going into hospital that did it. My personal assistants were just laid off by the agency. That would not have happened if I had been their employer.' User 2

'I would love to change mainly because the girls do not get enough money... I am happy with the people, the girls, but not the money they get.' User 5

This was ironic given that one of the council solicitor's arguments against direct payments was that social care users would not be good employers. Senior officers had also been doubtful about the

ability of service users to recruit 'suitable' staff. However all but one user (U13) identified prospective employees they had met through agencies under contract to social services.

Users considering direct payments were primarily interested in a relationship with staff. All of the community care users interviewed rejected market principles and the commodification of care, whether or not they ultimately decided to move to a direct payment.

'I am confident that if we are allowed to get on and organise things for ourselves we will manage okay. The staff are more loyal to me than they would be with the agency... I want to treat them properly. It is practical not philosophical, mutual respect; it works for us'. User 2

The emphasis on reciprocity extended to both the 'public' and 'private' aspects of the relationship. Users sought to achieve just treatment for care workers through taking over employment responsibilities to ensure they received a fair proportion of the public money spent to secure their labour.

'Money is wasted on management costs.... It is wrong for them to rake off a profit. Their staff should get higher pay and the money should be going to help disabled people.' User 3

'She would be better off, as they say 'cut out the middle-man'. If there is not agency getting a rake off there would be more money to pay her' Carer 1

They also talked about reciprocity at a personal level, through mutual respect and understanding, sharing experiences:

'It's got to a stage when personal assistants are so heavily involved in my life, they are colleagues and friends. Partnerships, user and personal assistant aware of each other's needs, not a consumer and a provider of a service, not a boss - employee relationship. ... Even Paul who works just 4 hours a week, is a friend as well as a worker. Little Becky, a kid who had had a hard life, had never been to the theatre, ballet or opera. She got a chance to do that with me. It enhanced her life, it works both ways.' User 2

'My wife has a lady she is happy with, they are on the same wave-length.' Carer 1

Practitioners recognised the importance of relationships between users and personal assistants:

'One chap on ILF has now transferred to the independent sector. ... His home carer has transferred to the agency to continue the relationship with him, but still works for us part time. Everybody is happy with that.' PR.8

'A few people I have talked to resent control being taken from them, they are made to feel belittled and de-skilled, encouraging disablement. Direct payments could help that because it allows a relationship between the user and carer that would break down formal barriers.' PR.32

One independent observer appreciated the potential of direct payments for overcoming some of the problems she was aware people experienced in their care arrangements:

'Home care services do not do what people want. They can sometimes just manage their own personal care but not housework, they are depressed because their net curtains are dirty...' Manager, Age Concern

However she objected to individual users/ citizens being left with responsibility for remedying the defective outcomes of community care policy.

'I am concerned that older people want to use direct payments to improve the working conditions of their care workers. It worries me that individual members of the community are tackling social justice issues that should be dealt with at a political level'

Most users also said that they wanted to be able to choose what tasks were carried out and when, and to have the flexibility to change their care arrangements to suit themselves and their staff, without having to consult anyone else. Their hopes for achieving more say and greater flexibility were based on their expectations of a relationship, rather than a shift in power from the provider to the user. 'Empowerment' meant lack of outside interference in that relationship.

'I will not have to go 'cap in hand' to the agency wondering what they will allow. There was a 'Who- ha' when I asked for a change after three years..... The staff were happy to change their shift patterns, but the agency and social services said no'. User 2

One user described how she realised this aspiration:

'My personal assistant is brilliant. She needs the hours to fit around her kids, so we negotiate to suit us both'. User 3

Some users suggested that being 'in control' would have psychological as well as practical benefits:

'It's going to be an individual thing but anybody who takes it up is going to feel more independent. Your own dignity and self-esteem are enhanced because you are felt to be responsible enough to manage.' User 2

In 2002 people receiving direct payments in Fletcherford were positive about the outcomes and prepared to recommend the initiative to others:

'I would advise anyone to go for it, it is wonderful. If you have any problems the support worker is there. Direct payments are there to help you so you do not have to rely on social services.' U14

The daughter of the first two people to receive a direct payment acknowledged the benefits for her family, although not without reservation:

'It has made a real impact on my mam's quality of life. She sleeps better and is better in herself, despite having lost my dad... We chose the people so she gets continuity..She likes and trusts them. But I have found that direct payments are nowhere near as flexible as the literature suggests ...' Carer 2

Nevertheless by 2002 relatively few people had enquired about direct payments and even fewer were receiving them.

8.6 Obstacles to Success

Users' and practitioners' accounts of their experiences show that the issues identified in the planning process, discussed earlier, deterred most community care users from receiving direct payments, and limited the choice and control enjoyed by those who did.

8.6.1 Promotion and Take up

The decision was made at the planning stage to adopt a 'low key' approach to publicity and promotion. The first planning manager (1) had advocated that the council adopt a 'marketing' approach to direct payments. However the solicitor had warned:

'It would be immoral to promote or market direct payments, you must just make information available... you can not empower them by leading them in directions they do not want to go. I am a great believer in empowerment but not at the cost of mental health, stress and strain.' Reference group meeting, June 2000

Promotion was 'low key' despite the opinions expressed by practitioners in 2000 that lack of general awareness about direct payments would be the major obstacle to their successful implementation. Practitioners said that most people in Fletcherford had still not heard about direct payments by late 2001.

'It needs more publicity and leaflets, there are none here We need more training for social workers.' PR.10

'For mental health services we need a lot more information for us and service users, regular contact from the scheme, posters, general awareness raising.' PR16

Only one practitioner from each team could attend an 'awareness day' organised by the support service, because of the many demands for training on policy changes. Practitioners did not feel they had enough knowledge of direct payments to share with users:

'I am not much further on what it is about. I would want to know where to direct the service user. When I have mentioned it, I have not known enough to relieve their concerns that 'it is too much hassle' ... 'PR.29

'I am not very comfortable with direct payments at all, I do not feel as if I have enough information to discuss it with potential users, not detailed practical knowledge' PR.32

Some practitioners suggested that they needed positive role models of satisfied direct payments users to share with clients:

'It is difficult to sell them when I have not felt confident and comfortable We are all a bit unfamiliar with it, waiting and seeing how it goes.. hearing people talk about their experiences. It is getting the first ones to do it.' PR. 21

Users who opted to 'wait and see' shared this attitude:

'I think direct payments sound like a good idea but it is up to my wife. I will watch and see what happens. ... In a year's time if everyone is happy who has gone on to direct payments I can say to my wife "there is the proof" ... 'Carer 1

One user was suspicious about the council's 'low key' approach to the initiative:

'The council's attitude is 'don't tell anyone and they won't ask'. They do not like the idea of direct payments meaning users can take control and make decisions.... If the council are playing it down as much as possible, then people will not ask for it.' User 15

However practitioners were usually the key source of information for community care service users and they did not see themselves as deliberately withholding information. Instead most practitioners, who had not dealt with a request for direct payments were, by the end of 2001, simply preoccupied with other work demands and policy changes:

'They are not at the forefront of my mind, I do not think about them automatically.' PR.15

'Hands on people are not involved enough to understand what is happening. It seems there are lots of disjointed changes. We get started on one new thing and then something new comes along and impacts on it and we get confused about which initiative it is we are implementing' PR.19

One practitioner had tried to generate interest:

'I did a trawl of all of my caseload. One was interested but then said no. There was too much hassle and not enough money.' PR12

She suggested that the authority and the support service needed to be much more pro-active if they genuinely wanted to promote direct payments:

'It depends how serious they are about direct payments. There should be more promotion in the local press, advertising, posters in the Civic Centre reception, the support service worker should hold surgeries in the day centres, they should get experienced users to talk about it. It should be heavily promoted to generate interest and confidence'. PR 12

Despite the decisions to take a 'low key' approach to promotion and to select only suitable users to demonstrate success, the impression many council staff had was that the conclusions of the 1997 consultation were correct, there was little local interest in direct payments. This vindicated the stance of senior officers who had argued that the initiative merited a minimal resource commitment.

8.6.2. The contract for the support service

The contract between Fletcherford council and the support service gave the latter responsibility for publicising and promoting direct payments, as well as training users and practitioners. However the support service manager was concerned to control the flow of referrals to the part time support worker. She therefore supported the 'low key' approach favoured by council managers. When the support worker was appointed there was already a waiting list of people who had enquired about direct payments. He also had to develop links with established local voluntary organisations as well as find his way round an unfamiliar community. Although he was aware that his performance would be judged by the amount of interest he generated in the scheme, he felt his first obligation was to advise those who had already enquired about direct payments.

Before the support worker's appointment his manager was asked to visit people who had enquired about direct payments. The care managers who accompanied her considered that she deliberately tried to dissuade some clients from pursuing the option, by making direct payments sound too complicated or inflexible:

'The initial discussions did not go well because of the support service manager. She made it seem too technical and difficult, as if she was deliberately trying to put them off. People need someone reassuring saying do not worry, they want issues minimised' PR 9

Economic theory predicts this approach to the management of resources by service providers in a market situation ('cream skimming') where agencies receive a fixed fee, irrespective of the needs of individuals, and are therefore motivated to select potential users likely to be least costly to provide for, those with basic care needs requiring low levels of advice and support. The Social service managers supported this approach using the expression 'cherry picking', to describe the process of selecting the users that were perceived as least likely to experience problems in

managing their care budgets and packages and so most likely to demonstrate the advantages of direct payments to other disabled people.

The secretary of the local umbrella organisation for disabled peoples' groups suggested that the council would have had more success in generating interest in direct payments if they had used established local networks:

'Bringing a support scheme in from Macville was a mistake. They are perceived as not understanding local people... Our group is the official voice for disabled people.. I have not been consulted on the development of the local scheme or asked to participate, despite being a disabled person and the secretary of the U.V.O. I would have thought we would be the ideal organisation to channel communication, we have a mixture of disabilities and impairment and a mailing list of 1300 disabled people. They certainly have not come through us to get in touch with all the local groups in one fell swoop ... to let us circulate the information'.

User 15 (also secretary of the Users' Voluntary Organisation)

8.6.3. The direct payment rate

Planning group members were unable to press the case for direct payments to be index linked to market prices. As they predicted, worries about recruitment affected all users considering employing staff through direct payments. However it was anxiety about having enough resources to cover emergencies that ultimately deterred some users. Practitioners in both surveys said that some people would like to have a direct payment without the responsibilities of being an employer. Market rates were needed to enable users to purchase services rather than employ staff:

'They should increase the direct payment rate to the agency rate to give people a choice. They should be helping us to find ways of getting a direct payment without employing someone. ' Carer 3

People were deterred from even expressing an interest in direct payments:

'They do not see the hourly rate is enough to cover all they have to do. It is not worth it for the extra responsibility of hiring and firing. They would rather complain through a third party, stand one step back.... The only question I have ever been asked is 'how much is it?' and then they are not interested.' PR.12

Even those who pursued an application, did so recognising that they might need to subsidise care costs from their own income, as well as making means tested contributions:

'The direct payment rate is too low... If you cannot pay enough you cannot recruit and retain quality staff. Also there is not enough to buy in holiday cover from an agency ...

I will use an agency for back up. I will have to make up the difference ' U14

The first direct payment users were convinced that another way they were being expected to 'pay' for managing their own care budgets was by sharing their own 'exploitation' with their staff:

'Social services pay general agencies £7.75 an hour but we still only get £7 an hour. We should be able to offer competitive rates. I feel that direct payment users are being treated as second class citizens, we do all our own administration... social services are trying to get care on the cheap' Carer 2

' We are doing social services' dirty work for them, paying low wages. ' User 2

A mother and daughter were interested in using direct payments from both the council and the ILF, to enable their care worker to leave the employment of an agency providing poor pay and working conditions. However they withdrew when they realised care staff could get more pay than the direct payment rate afforded if employed by one of the specialist agencies. The preferred agency was persuaded to employ staff for them:

'We had to negotiate with Goodcare to get them to pay over £5 per hour. They pay £5.20 per hour out of the £11 they get, but with a direct payment we would have only got £7 an hour to cover everything' User 8a

This improved life for the staff but did not prove to be an easy option for the users:

'The package is already very complicated because they charge different rates for public holidays. I have been tearing my hair out. There were two holidays last month I had to sort out and then the agency lost the time sheets. They have no communication and that is the heart of management.' User 8b

8.6.4 Delays and complications

The process of approval for direct payments had eight steps and included obtaining the signature of the director. At the end of 2001 twenty of the thirty-two practitioners interviewed said that they did not understand the procedures and so could not explain them to users. Even practitioners who were actually helping individuals through the process felt confused and frustrated:

'My problem has been that policies and procedures are not yet sorted out; there is no format for me to follow. If I go and do an assessment and somebody wants home care I know what paper work to complete and where it needs to go. ... These were big issues to them and me, how to kick start the process..' PR 2 (Care manager for the first two people to get direct payments)

The daughter of the couple concerned also described the experience:

'We approached social services soon after February 2000 because I had heard that direct payments were being extended to over sixty- fives. My parents would not have wanted to change if the package they got had been satisfactory.... Social services did not really know about direct payments. I was passed from one person to another. The planning manager was keen and helpful, but she left.... They dragged out the process for too long. There were other models Fletcherford could have adopted instead of inventing their own. I felt they were just paying lip service to the ideals of direct payment.' C2

The care manager of the only person with a learning disability to request a direct payment explained:

'We need a step by step guide but not produced by people who do not want them to have direct payments... It is the first one I have done and I am learning the procedures as I go along. There is natural apprehension through lack of experience but I feel that nobody knows what they are doing in this local authority. They do not understand the issues relating to learning disability...' PR31

By May 2002 her client had still not overcome the obstacle (the 'capacity' issue, discussed in chapter 7) to getting a direct payment.

It was not until six months after direct payments in Fletcherford had won political approval that the council solicitor and senior managers settled on the wording of a 'Letter of Agreement' for users to sign. Repeated revisions to the document caused delays for subsequent applicants that neither they nor their care managers could justify.

'The idea of a direct payment was to make our lives easier to give us what we want that social services could not provide but now it is causing me more stress..... They should not leave people not knowing what is happening. That is why they get anxious and change their minds like I did. It is all taking too long. I am worn out and worried.' Carer 3

The lengthy, complicated process of accessing direct payments reinforced the view that was developing amongst practitioners and users that direct payments were difficult to arrange and manage. Practitioners were unable to explain or expedite the process. They were increasingly reluctant to even suggest direct payments to people they did not think could cope with the stress of uncertainty and delays, whether or not they felt they could ultimately benefit. While people waited for direct payments some prospective employees found other jobs.

'I waited over a year. I was going to employ a friend but she got another job.. It takes them so long to make a decision. Too many meetings, too many people involved instead of just one person saying yes or no. It really should be a simple and straightforward process if social services would get their act together.' User 3

The most determined (or desperate) service users were not deterred despite the obstacles. However two of the first four people to request a direct payment died within two weeks and two months of receiving their first payment, having waited eighteen months and a year from their initial enquiry.

Some of the users who expressed an interest in direct payments decided to 'wait and see' how other people fared because the process seemed so complex.

'The whole experience of trying to get a direct payment undermined my confidence.'
User 2

Others 'dropped out' altogether. Users were sometimes helped by their care managers to resolve problems with their care arrangements in another way, like the six who obtained ILF.

The director (2) would not approve a direct payment unless a detailed care plan accompanied the 'Letter of Agreement'. The explanation given was her accountability for public money. She could not justify, to councillors and corporate colleagues, handing cash to service users unless conditions were attached to how it could be spent. Users experienced this as undermining the flexibility they expected in return for the extra responsibility involved in managing their own care arrangements.

'We would like more control and flexibility. Despite our contribution in terms of time, skills, knowledge and money to the package, social services are still prescriptive over what we use the money for... We are still stuck with a rigid care plan.' Carer 2

8.6.5 Approval for Personal Care Only

The decision to obtain political approval for direct payments for personal care only soon presented problems for practitioners when users asked for cash to replace other services. The strategic manager explained that she wanted to keep the scheme 'simple' initially. However practitioners consulted in 2000 had predicted that users, who would not necessarily want to be employers, might want to buy alternatives to the limited range of day and respite services available through social services contracts. They were correct:

'I thought about it in connection with respite.I can not go for a hip replacement because I will not leave him. He has been ill for four years and as bad as this for 12 months, after respite in a nursing home made him much worse.' U5 a

'I need a direct payment to pay someone to come in the house and stay with dad while I go into hospital. We are entitled to respite ... 60 nights a year in a nursing home but we are not using any.My social worker is trying to get us the money but she is having a struggle... I want to arrange respite in the house because dad does not want to go into a home. He is old and he is ill... My social worker said I was the first person to ask for a direct payment for respite so the delay was while they sorted it out.' C3

The social worker involved was aware that respite was not covered by the 'very basic' local scheme. However she was determined to find a way to convert this man's eligibility for 'respite' into a direct payment, with the support of her team manager. She justified her intention to circumvent the obstacles in the local system by reference to wider policy objectives.

'We are planning for a carer to go into hospital. Her father is an older man who has always refused services. We are still waiting to get direct payments for respite. We are trying to get it sorted out to suit them, to get round the rules and systems that do not fit. There is a need there and we are trying to meet it and give them what they want. That is what it is supposed to be about, choice, keeping people at home and supporting carers. My manager is not the problem. He will do everything he can to make it work. If it was a normal care package I would just go through him but because it is a direct payment everybody has to be involved.' PR13

Users had more ideas:

'I think that it would be better if you could get direct payments for equipment. We have to use aids that are not suitable or buy our own.... I was provided with a table to use in bed but it will not fit. Also they gave me a spinner to help me onto the commode, but the spinner is too fast and I am afraid of falling.' User 3

'One thing that would be better as a direct payment is transport to the day centre. My mother gets on the bus at 9'30 and does not arrive there till 10'45. She gets very cold because of the opening and shutting of the doors as people get on with the chair lift.' Carer 2

'I would rather turn the Sitter Service into a direct payment. I do not see why they should get the money and not the girls.' User 5a

'Younger people would rather have a direct payment than go to day care, they want to go out and about and do normal things.' PR.31

By February 2002 there were no procedures in place for converting any of these services into direct payments.

8.6.6. Assessment: ascribed and self defined needs

The assessment of need is a separate process from agreeing a care plan that sets out how needs are to be met, according to community care guidance (D.H.S.S. 1991). The decision whether the user gets a direct service or cash in lieu is clearly part of the care planning process. Nevertheless it was decided during the planning stage that users requesting a direct payment to replace services, would be subject to a re-assessment. This offered reassurance to senior officers who opposed direct payments that public money would not be handed over to individuals without the mediation of

'professional judgement'. However users and carers on the planning group questioned why this was necessary and the first people to request a direct payment said they felt they were being punished with a re-assessment. Some practitioners in the 2000 survey expressed discomfort at the prospect of 'gate keeping' direct payments.

Users explained that a community care assessment required them to discuss issues of a deeply personal and intimate nature, often matters they have not shared with close family. Assessment meant focusing on their own 'weaknesses' and those in their informal network of support. Often they were expected to confide in virtual strangers, having just met the care manager who visited for the first time in order to carry out the assessment:

'My mother had to have two assessments because of the time interval between her asking for a direct payment and getting one She was very distressed by the assessment process. It was very intimate and intrusive asking in great detail about her personal assistance needs. I did not realise how much it upset her, made her feel useless. It was traumatic.'
Carer 2

The assessment usually includes a 'means test' (to ensure that the individual does not have enough money to be disqualified from the council's assistance), which people also found degrading. One person decided not to pursue a direct payment when she realised a 'financial assessment' would be required. Care managers were disinclined to pursue the issue of charge avoidance:

'They said they did not have more than £8k each in savings. I did not look any further'. PR
32

Some practitioners objected to means testing on principle believing that social care should be universally available. Others felt that it introduced yet another unwelcome complication. Ten of the users I interviewed were using 'private' resources to pay for care (from relatives or personal benefits) as well paying the council's means tested charges.

Disability rights campaigners have argued that users should define their own care needs and that the importance of the user's insight is particularly crucial to the success of a direct payment (Oliver and Barnes 1998). Planning manager (1) described how senior managers worried that direct payments would generate extra demand for community care resources:

'The fear was that direct payments would somehow bring disabled people out of the woodwork we tried hard to say, if these people need services they are likely to be in the system. With something like personal care, if people need it they need it Yet it was constantly reinforced, "if you give people an inch they will take a mile, they will just want

more and more" I was very aware that people found a lot of care intrusive and want to minimise it' (June 2000).

'Care providers' in the 2000 survey maintained that 'care managers' tended to over-estimate the needs of users. The accounts of disabled people in Fletcherford confirmed that users and carers were more likely to deny than exaggerate their needs. The 'community', families, friends and charities were providing care that the statutory services might otherwise fund.

'If my husband could not do my hair and my feet and turn me at night, I would need help but I would prefer to be as independent as possible. My husband worries about what would happen if he was not there, so we have talked about it. I would use my benefits to pay someone and I would only ask for a direct payment if I really could not manage. I would ask the day centre staff to do my hair and give me a bath. I am sure my family and friends would see to the housework.' User 10

'My friends are all retired and they are great. One is seventy and we go on holiday together. I just take a hoist and she looks after me...' User 12

People just wanted a 'normal' life:

'At the moment my husband and twelve year old son do it, or I would have to stay in the house and wait for the agency to come. I need to be part of the world. I have not altered inside because I am disabled. It is as if you become a person who can be told when to be in, when to get up or have a bath. My twelve-year-old son is brilliant. I am the only mother he has ever known so he is used to helping me in the shower' User 15

For community care users, the aspiration of 'independence' encompassed the New Labour ideal of self-reliance along with the disability rights movement's ideal of self-determination. It was a matter of social conscience as well as personal pride. People did not want to use resources that were required by others in greater need.

'I would not like to take a service if other people need it more.' User 10

'I just plod on because I can see that there are people in greater need. I have got my husband, my daughter and all my mental faculties. Some people do not know what to do and they live alone' User 11

Individuals also tried to avoid the delays and perceived stigma of going through official channels to obtain non-rights based services.

'The social worker needed notice to order an ambulance from the Red Cross to move me into this bungalow. My husband rang the NHS ambulance service and paid £50, so we were able to co-ordinate moving me with removals...' User 3

One lady who had carried out her 'civic duty' through military service found that it was not the state that reciprocated when she needed help.

'We go together for respite to a RAF home, it was donated by a family who lost sons in the war. The RAF Benevolent Fund also pays the airfare and taxi fare ... I was in the Royal Air Force, I was a sergeant for the whole of the war.' User 5

Care managers were conscious of their roles as 'gatekeepers' of community care resources. Through their assessments they committed public money to finance care, whether provided directly by services or through direct payments. The opinion widely expressed in both practitioner surveys, was that resource rationing was due to inadequate funding of community care rather than the expectations of users, who were generally undemanding:

'People are generally satisfied They are practical independent people, they see asking for more help as their own failure. Users choose to have less rather than more.' PR.23

Users were encouraged to accept help from families and neighbours. Care managers explained this approach:

'Keeping people at home involves working within a limited budget. We have got to think laterally, drawing on everything and everybody including relatives, state and independent sector. Anything you can do to keep them at home, or make the best quality of life you can with money available' PR.4

'We try to be creative and use free voluntary sector resources. When people want to live independently there is a capped limit on what you provide. It is difficult if they do not have other resources or networks for back up.' PR.23

The revival of charitable endeavours to reduce reliance on the welfare state was an ideal of New Right (De Jasay 1992, Green 1999). However this combining of public and private resources appeared to be a New Labour strategy intended to counter the effects of the 'dependency culture', to recognise the role of the 'community' in supporting its members (Dept of Health 1998a) and the importance of the 'new contract between citizen and state' (DSS 1998, 80)

Some users accepted services because they were concerned to relieve the 'burden' of responsibility they felt they placed on their families:

'Mam would have been happy with two days at the centre, she only goes on a Saturday for our sake.' Carer 2

'I have always been determined to speak up for myself and to not be a burden on my family. It is me that has the disability. I did not agree that my family should be handicapped by it.'
User 2

Practitioners described using the assessment process to define, quantify and present care needs in a way that suited the council's eligibility criteria, 'ceilings' and approval procedures for direct payments.

'With direct payments I can call gardening 'domestic work' to get the hours. It is no good having personal assistance if she cannot get her wheelchair down the path for weeds'
(PR.9 in conversation about an assessment for direct payment)

For older people, social workers struggled to get enough care hours to meet even basic physical needs. Some users recognised the efforts care managers made in battling through the system to get them the best package they could:

'We get two separate packages to get more hours. The social worker is going through the NHS to try and get us more because it takes two to lift my husband.... He gave me another six hours, but the manager stopped it. The social worker was very upset. I get two workers at night but only one on a morning. I help the morning girl... I fell yesterday so now I have asked the agency how much I would have to pay privately for a second girl. We get two at night because one is supposed to be here to help me bathe, that was the social worker's idea' User 5

'I also have had a very good social worker who is as cheeky and awkward as me. She does not give up.' User 2

8.6.7. Health and Social Care

The 1999 Health Act 'dismantled' the National Health Service internal market created by the Conservatives in government. 'Primary Care Trusts' were introduced with responsibilities for both providing and securing services to meet local health needs. These policy developments influenced the work of Fletcherford social services between 2000 and 2002, encouraging more collaborative working between health and social care professionals, single 'joint' assessments and pooled resources to fund community care packages. The Health and Social Care Act of 2001 obliged councils to offer direct payments to a wider user population. It also threatened that, where local agencies were unable to develop satisfactory partnership arrangements, 'Care Trusts' could be imposed, taking social care services out of local democratic control.

In Fletcherford, as in many areas, mental health and learning disability services had already begun to move towards integration. Mental health practitioners worked in multi-disciplinary teams from a health centre base, and the health trust provided community support and day services. For people

with learning disabilities there was already some pooling of budgets, through the transfer of funds released from hospital closures to councils to develop community services. For older people and people with physical and sensory impairments efforts were still concentrated on developing a shared data base and a single assessment framework, to overcome fragmentation and duplication in community care interventions.

Practitioners felt they worked well together; any 'seams' in their services appeared at the political/senior management and budget allocation level. Amongst practitioners there was a general view that the government would eventually impose Care Trusts to run community care services, whatever the experience of the 'pilot' areas. The care management teams that had travelled least distance down the road to integration with health (for older and disabled people), were the most optimistic about the prospect:

'I think that joint working can only be good for services users. We are supposed to be working to the same ends.' PR.17

Some thought that Fletcherford would be quick to grasp the opportunities offered as it had with the whole 'modernising' agenda:

'Once we move to a Care Trust and joint working, it should improve things. This council is in advance of other local authorities, a front runner.' PR 11.

Learning disability practitioners had mixed feelings, comparing the possible advantages of a being part of a 'universal' and popular public service with those of cohesion, responsiveness and accountability to the local community:

'I sometimes think that there may be more funds available because people are prepared to pay more for health services. But as a local authority service we can respond to local needs.' PR6

'I think Care Trusts will happen eventually but I am concerned that health will dominate. GP attachment might improve relationships with particular practices but will it lead to fragmentation within social services?' PR.13

The mental health team social workers were most pessimistic, predicting that integration would destroy traditional relationships with users concerned with empowerment and advocacy, replacing them with a focus on social control. The social model of mental illness was in demise along with their job satisfaction.

'We are overwhelmed as social workers by health dominance. The only role we do maintain is the Approved Social Worker. We are demoralised. ... Our traditional role of advocacy has been eroded... PR.14

'Integration means our little bit compared with the huge health service. Different backgrounds and different values, if you have come up through nursing you will do what the consultant says without questioning... We question more, advocate. Some health staff do question but the culture is "say yes and go along with it". We look more holistically at the person their family and the environment than in health. There are good theoretical models in social work. We look beyond individual pathology in mental health.' PR.15

'What seems to happen is government says so health does. Because health are so powerful we look awkward when we want to take things more slowly with a sense of purpose... but once in health we will have no say. Health professionals, nurses, are dictated to they just do as they are told. In social services there is room for negotiation'. PR 29

In this context mental health social workers were still enthusiastic about the liberating potential of direct payments for service 'survivors' but were daunted by the problems of most care plans being dominated by services provided under the auspices of health and therefore not convertible into a direct payment.

Meanwhile the guidance²¹ that followed the 'Coughlan Judgement'²² intervened. This required the re-assessment of people receiving intensive community care services (particularly in nursing homes) and, where their care needs were deemed complex enough, health taking over funding responsibilities. There was general support for this development in Fletcherford. Managers and practitioners argued that the National Health Service had for many years 'offloaded' responsibilities for supporting those with chronic illness and disability to social services. Also people re-classified as needing 'continuing health care' were no longer liable to pay charges as New Labour maintained that health services must remain free at the point of use. However for the small number of people in Fletcherford who requested direct payments, re-assessment in this wider policy context threatened to deny this choice to those with high or complex needs.

The 2000 guidance said that direct payments could not be made for health care and this seemed to welcomed by those in Fletcherford who wanted a 'basic' scheme only. Senior managers in both social services and the support service favoured selecting people with 'simple' care plans. The threat that the choice would be removed for people with complex needs worried social workers and their line managers, as they suspected that senior managers would favour outcomes that made expensive packages the responsibility of health:

²¹ HSC 2001/015:LAC (2001)18

'What if they come up as continuing care when I reassess them? Health will pay but they will not get direct payments. It is how you intepret it. If health pick up the cost they will not be able to employ who they like. We have built up the hopes of people who want direct payments..' Social worker

'Nobody wants to know about these problems ' Team manager

(Excerpt from conversation 14-2-01)

The introduction of direct payments in Fletcherford from April 2001 happened before the circulation of new guidance on the further extension of direct payments in the Health and Social Care Bill.²³ The advice provided by department of health civil servants was that new guidance would be developed on the basis of 'street level' experience:

'It is too blunt a statement of the position to say no direct payments for health care. Users like to get services in as joined up and seamless a way as possible. We are keen for people to explore locally the freedoms that are available. That is not to say direct payments are appropriate for all health care needs. With direct payments it is not as clear as it might be about how much they can be used for health care needs because we want to see people using them flexibly. We want to see how the users get on. We may develop guidance based on practice.'

Advice from head of 'social care group', in the Department of Health, 21-5-01

However this did not provide practitioners with the 'top down' pressure that they needed to overcome local resistance to flexibility. Another civil servant included a comment on the political dimension in her advice:

'The guidance suggests a way of getting round the problem. Health can transfer money into a pool. The legal position is that direct payments can be used only on the social care element, but research shows that people are using the money for personal assistants to carry out basic health care. At the moment transferred money cannot be used for health functions legally. Money transferred from health is to be used on social care, we are politically not ready for more than that yet.'

Civil servant in the Department of Health 'health care group', June 2001

The social workers of people requesting direct payments used the re-assessment opportunity creatively to get approval for the care plans their clients wanted:

'When they talked about me having a re-assessment against the continuing care criteria I was worried because the managers would see how my care package had built up over the years as my condition got worse. But my social worker made sure they did not cut my hours. She got money in from health and now she has applied for the ILF, so this is going to save the council money.' User 2

²² July 19th 1999,

²³ Draft guidance issued in August 2002

Practitioners in carrying out 'single' assessments of individuals were expected to continue to distinguish 'health' from 'social' care needs and ensure that in care plans direct payments from social services only paid for the latter. They often used discretion in their efforts to allow their clients' choice and control in their care packages.

'I assessed her as needing help to get up but she has got an exerciser she uses herself and wants a personal assistant to help. If a physiotherapist had done an exercise regime and trained the personal assistant, we could have put it in the care plan but she will probably do it anyway Whether that is health or social care, I would not like to begin to worry about'. PR2

Despite the government's promotion of 'seamless' services practitioners confronted inter-agency boundaries to be circumvented to meet even basic needs.

'We can ask for joint funding but we have got to get health to agree on a case-by-case basis. I am working with a lady whose legs are swollen. She needs more care, to bathe and cream the legs. I have asked the district nurse to go in but she says it is not a health issue until the skin is broken ... But the lady is benefiting from having her legs creamed unofficially once a day. She needs it twice daily. They are officially just doing personal hygiene. We are asking health to share the costs and monitor skin care. Prevention is the policy but not in practice ... Another lady is incontinent in urine. Her bedding is wet everyday. The washing machine is broken temporarily. I rang the continence nurse to ask for the emergency laundry service, but they will only provide and launder single sheets and she has a double bed.' PR23

Practitioners did not always overcome these obstacles. One user found that her most pressing need for pain relief could not be met through a direct payment because of seemingly insurmountable barriers to 'joined up' working:

'... Social services will not fund the personal assistant to put on my Ibuleve cream, they say it should be health provision but the district nurse will not do it. The biggest need I have is for pain relief.' User14

8.7. Pioneers or Bold Adventurers?

It is risky to try to generalise from the experiences of such a small group of people about what sort of people request and receive direct payments. However most direct payment schemes seem to start with a 'handful' of determined people and grow slowly (Dept of Health returns 1998 to 2002). I therefore reviewed the characteristics of the first people to express an interest in direct payments to consider how 'typical' they were of the potential population. Because of the limited publicity in Fletcherford, those who enquired about direct payments were amongst the better-informed community care users. All had links to an organised users' group or advocate, or had a friend or relative

working in social or health care services. They had also been sufficiently interested in change, or sufficiently dis-satisfied with their existing provision, to explore alternative arrangements.

Nevertheless amongst these better-informed users a distinction emerged between those for whom getting more involved in decision making and taking more control represented an opportunity and those for whom the prospect of more responsibility generated anxiety.

There was no obligation on social services to inform all potentially eligible users about direct payments by 2002. It may have been that the individuals whose interest was recorded were those who had not been diverted at the first hurdle by council staff who did not think that they were 'suitable' candidates. It was in the Support Service's interest to record as many enquiries as possible (therefore counting two members of the same household separately). It was in the interest of practitioners who felt that helping particular individuals to get direct payments would be difficult and time consuming (because of the complexity of their circumstances) to deter them rather than encourage further discussion. However this was probably not deliberate. It seems, from the accounts of the majority of practitioners who had not yet successfully supported a client through the process of getting a direct payment, that they could have unintentionally deterred people. When their responses to questions about receiving direct payments were hesitant this may have been enough to undermine the confidence of users in the feasibility of the option for them.

None of the first group of people to enquire about direct payments was in paid employment, although several were very active in voluntary organisations. They were 'socially included' in a relational but not an economic sense (Wessells 1999). All but one was eligible for 'selective' community -care services; therefore they had limited personal means. They could not be described as 'well off' or privileged. However those who survived the application and approval process had, personally or within their family, knowledge and experience relevant to managing staff and budgets (see table 8.2).

'The feedback is anxiety about being the employer and responsibilities for the whole thing. If people have never been in that situation, it is quite daunting. Some people would thrive on the challenge and opportunity' ... PR 21.

Practitioners suggested that some users were more assertive and confident than others. Users drew similar distinctions in the context of direct payments.

'I got what I wanted by speaking up... But some people, especially the older ones, do not have the confidence to fight. They worked hard all their lives and they accept what they are given. Some of them do not even see a social worker until they have to go into hospital. The idea of getting money from the council scares them...' User 2 (Interview 3)

Fletcherford's approach made the responsibilities involved in direct payments more threatening and onerous than necessary. For some users the expectation of empowerment from direct payments is associated with the role of employer and the opportunity to wrest power from council and agency managers to be shared with staff, along with improving their pay and conditions. However for others the idea of being an employer was a threat:

'I pulled out the last time because I did not want to go down the route of employing somebody. It sounded too complicated. Then my friend said I could use an agency and get less hours.' Carer 3

Being an employer did not appeal to this user who had years of experience managing a care budget from the ILF:

'I am happy with ILF but I do not want to switch completely to a direct payment. I would be responsible for paying for all the services and managing them. I am not saying that it would not be better but I do not want the hassle' User 12

Practitioners had predicted in 2000 that many users would be deterred from seeking direct payments by 'uncertainties' about the implications switching from services. If care managers had been able to answer questions more confidently and had more accessible information to share, there may have been more interest expressed by those who had heard about direct payments. A more straightforward approval process, a higher profile support service, higher payment rates, less restrictions and conditions attached to use, a more inclusive approach to 'capacity' and better arrangements for combined health and social care packages would have made direct payments more attractive to more people. There were some users and practitioners who were following the progress of the 'early pioneers' before deciding to act:

'It takes a certain sort of person, a go-getter, to go for it to start with, or a nutter, go on say it' Carer 1

Informants generally were of the opinion, nevertheless, that direct payments would not be everybody's choice. The following excerpt from a discussion by wardens of 'sheltered housing' reveals that people who were able to witness the day to day experiences of an important demographic group of community care service users appreciated that individuals would respond differently to the opportunities offered by direct payments. They said that some older people would enjoy the responsibilities involved in managing their own care, but others would be intimidated by the prospect:

'They [residents] are interested in anything that will keep their independence and enable them to stay in their own homes'

'There are lots of ours who will not admit to needing community care, they might want to know about it.'

'They want their privacy and their independence'

'Yes, for those with carers because they might want some help with the money. Lots of ours have families coming in.'

'It would scare some.'

'Some just want other people to sort things out for them, like us. They are happy for us or their social worker to make the decisions if they do not have families.'

(Notes from a group discussion of Sheltered Housing Wardens, February 2001)

The Age Concern manager in her role as an independent advocate for older people had received a complaint from the son of an elderly couple who had heard about direct payments and were worried that this was a prelude to social services 'abandoning them'. She recognised the problems with poor, unreliable, services (particularly private home care agencies) but she argued that the solution was not to expect users to take on the role of service commissioners and managers. Amongst the small number of users and carers I spoke to although they all sought quality services, choice, control, flexibility and independence (the official policy objectives), some would have preferred these outcomes without more responsibility. Some had learned from experience that a policy change with apparently laudable aims could result in a cut in quality and availability of services.

One enthusiastic user recognised that not everyone shared his confidence:

'I still want to be involved and active in old age. I can express myself assertively and get listened to.... I have already had an excellent service from social services but others have not been as fortunate. Everyone should get the same entitlement, not just across councils, within them'. User 2

One practitioner summed it up:

'The benefits are there, control over their lives, choice of care worker, but it is trying to convince people, feeling they are stepping off a cliff in leaving go of the support of SSD.. They are not confident about long-term support or emergencies... The elderly fear losing the continuity of social services involvement. They do not see it as a benefit. It is a threat.'
PR12

8.8. Concluding Discussion

Decision- makers with responsibility for planning the implementation of direct payments in Fletcherford had access to the conclusions of the 2000 practitioners survey. However the potential obstacles that practitioners had identified from their experience of working with community care users, were not addressed in the development of the local scheme. Decisions made during the planning stage, against the advice of most working group members, proved to be serious obstacles to individuals requesting direct payments and deterred others completely.

For expediency the council contracted for support for direct payment users through another authority. The worker was only available to local users two days a week and was not established in local voluntary and informal networks. No attempt was made to recruit a local disabled person to the post. Because the support service was a voluntary organisation funded by the council on an annual contract, the manager's concern was to secure the continued funding of her service. Therefore, despite her 'independent' status, she was disinclined to challenge social service decision-makers.

Lack of publicity and promotion, meant few community-care users had heard of or asked about direct payments by 2002. Direct payments therefore slipped from the consciousness of practitioners generally because they were preoccupied with excess demand, the pressures of implementing the wider policy programme and being 're-organised'. Cynicism about the value of policy changes and performance measurement increased amongst practitioners, who generally supported the principles and objectives of New Labour's policy.

The process of accessing direct payments and the repeated revisions of the Letter of Agreement created the impression that direct payments were inherently 'difficult'. Practitioners were unable to explain the process of accessing direct payments and many of the users who expressed an initial interest withdrew. This reinforced the impression held by some managers and politicians, and actively promoted by others, that there was little interest in direct payments locally. Thus a low level of investment into awareness raising, staff training and funding support could continue to be justified.

Individuals pursuing direct payments sought to achieve the ideals of choice, control and flexibility through a personal relationship rather than a market transaction. Jordan's (1999) distinction between the code of reciprocity in informal relationships and the market place rules of fair exchange was evident here. Users were also motivated by more abstract 'social justice' considerations, in

seeking fair treatment for their care staff and considering the needs of other disabled people when using community care resources.

Decisions made during the planning stage of the implementation process not only limited the numbers of people to pursue the direct payments option, but also restricted the potential benefits for users seeking the official policy objectives. Where users who enquired about direct payments eventually experienced an improvement in their care arrangements, whether through a direct payment from the council or the Independent Living Fund, this was achieved through creativity and the exercise of 'discretion' by care managers. Practitioners used their experience of community care to lead users through a maze of bureaucratic procedures, rooted in local 'ideological' resistance and ambiguous central government policy directives, to reach the objectives of direct payments.

CHAPTER NINE

Comparing Experiences : 'Bigtown'

'It ain't what you do it's the way that you do it'

Fun Boy Three and Bananarama (1982)

9.0 Introduction

Experiences of direct payments in another authority are compared with those in Fletcherford, through the accounts of the actors involved. Bigtown is another Northern council traditionally led by the Labour party. The contextual similarities and differences between the two areas are identified and their relevance to the actors' experiences and the outcomes of the policy initiative are discussed. By providing a contrast to the Fletcherford situation, the findings from Bigtown illustrate and support Pawson and Tilley's (1997, xv) thesis that in policy action '*mechanism + context = outcome*'. Experiences in another authority illustrate that the course and outcomes of policy implementation vary with interactions between historical, social, organisational and political influences and that the last are more complex than party allegiances. They also confirm that central government requires the contribution of public servants and citizens at the point of service delivery to secure the achievement of its policy objectives, irrespective of 'top-down' approaches to performance management and compliance.

9.1. Data

I interviewed the social services strategic planning manager with lead responsibilities for the introduction of direct payments in Bigtown, in February 2000 and he updated me on developments over the next two years. In the summer of 2001, he sent out letters inviting participation in my research to all twenty-eight direct payment users in Bigtown and to the twelve practitioners involved. Six users responded, but I was only able to meet four users and three carers. I do not have any information on the people who did not respond. The breakdown of direct payment users in Bigtown by source of disability (see Table 9.1. below) suggests that the people I interviewed represented the largest user group (white people, under sixty-five with physical or sensory impairments). I could not contact community care users who had not requested direct payments or people who had withdrawn, having expressed an interest. I therefore relied on the accounts of practitioners to compare experiences with those who had decided to stay with direct services in Fletcherford.

Six care managers responded to my letters, four were senior practitioners and all had some experience of direct payments. I interviewed another seven care managers I met while visiting

social services offices. They were aware of the local scheme and the principles of direct payments and had attended introductory training, but they had no direct experience. However one had had experience of the Independent Living Fund direct payments. These interviews with users, carers and practitioners all took place in September 2001.

Table 9.1 Practitioner respondents identified by primary client group focus

Primary client group	With Experience	Without experience
All adults	3 (senior case workers)	
Older people	1	4
People with physical/ sensory impairments	1 (senior case worker)	1
Learning difficulty	1	1
Mental health		1

I also interviewed the support service co-ordinator at the Bigtown Resource Centre for Independent Living in February 2002. The data used in this chapter includes the interview and conversations with the strategic planning officer between February 2000 and 2002.

All the people I interviewed to obtain data for this chapter were 'expert witnesses' because of their first hand experience of social policy implementation and the opportunities they have had to reflect on that experience.

9.2 Bigtown and Fletcherford : Similarities and Differences

Based on the accounts of the above informants, I will describe the similarities and differences in the contextual conditions for and experiences of the development of direct payments in the two local authority areas.

9.2.1. Consultation in Bigtown

Word spread about the powers granted to local authorities to make direct payments amongst networks of disabled people's organizations after 1997 and reached Bigtown. The user-led management committee of a resource centre in Bigtown approached local politicians, and one carer wrote to the social services director, requesting a local scheme. In 1998 the council commissioned a group of disabled people from a nearby university to research local interest in direct payments. Community-care service users received letters and consultation meetings were held. People were

asked their opinions on the principle of introducing direct payments rather than on the practical details. The report suggested that there was 'some interest' in direct payments but that people were concerned about the extra responsibilities involved. Consequently the decision was made to develop a support service alongside a direct payment scheme to alleviate some of the worries expressed by potential users.

It seems that Bigtown's consultation was a genuine effort to establish the opinions and concerns of local community care users about direct payments. It was led by an independent organisation, which could reasonably have been assumed to have the requisite knowledge and skills to win the trust of local disabled people. The people consulted used services, could have potentially benefited from the initiative and therefore had an interest in the outcome. There was nothing to suggest that people in Bigtown suspected that the council had ulterior motives in raising the issue of direct payments with them. Unlike people consulted in Fletcherford in 1997, users had not observed the council significantly reducing its role as a service provider through the development of community care policy.

9.2.2. Direct Payments and Community Care Politics and Practice

Bigtown is a well-established unitary authority led by a majority Labour council. The population was over 700,000, seven per cent were from an ethnic minority. In 2001 the council remained a large provider of residential care and the major provider of domiciliary and day care. Following the consultation, strategic planning staff encountered no resistance from the leading Labour politicians to the proposal to introduce direct payments. Councillors were concerned that the pay for personal assistants should match the rate paid to the council's home care staff. This was not only for social justice reasons but also to ensure that the council's own service was not subject to unfair competition through the government's best value initiative (DETR 1998). This meant that direct payment users could 'poach' the council's well-trained staff, recruiting individuals they had an established relationship with, an option that the direct payment rate did not afford service users in Fletcherford.

Direct payments were not seen by politicians or staff as a threat to the council services that dominated local community care provision and were the first choice of most users. The strategic planning manager said that the chair of social services strongly supported the proposal to introduce direct payments, reasoning that they would provide an alternative to independent sector provision for users who did not receive the council's own services. Support for the initiative from the users' management committee of a high profile council run Resources Centre helped convince politicians that direct payments were a 'rights' issue for disabled people.

The development of the 'mixed economy' in Bigtown meant that the council had 'block' (cost and volume) contracts for domiciliary care with two independent agencies. The demand for the council's services exceeded supply and practitioners were expected to use pre-purchased alternatives only when council provision was not available. This was unlike Fletcherford, where council services were generally 'closed' to new referrals and practitioners were expected to 'spot purchase' from a list of private agencies on rotation. Fletcherford practitioners could not show preference based on their opinions of the performance of particular providers. The community care market was therefore not truly competitive in either authority in the sense of obliging providers to respond to the price and quality preferences of their principal (users) or agent (care manager) customers. In Bigtown in 2001, many private residential homes were closing, so vacancies in the council's homes were reserved for people requiring relocation. Best value did not seem to threaten the council's direct services, possibly because as much larger authority Bigtown could achieve economies of scale that Fletcherford could not. Also the smaller council, as a new unitary, had inherited responsibilities to run existing services without commensurate revenue support from central government. In keeping with the national trends (Audit Commission 2000) Bigtown council, like Fletcherford, already had a policy of charging for non-residential services through means testing. Direct services were changing their focus to supporting people at home and integrating people into their communities in both authorities. However Bigtown care managers, particularly those working with older and disabled people, were dealing with people in crisis situations and had little time to focus on enabling and preventative work. As in Fletcherford, the council's home care service was generally highly regarded by users, practitioners and politicians.

9.2.3. Characteristics of direct payment users and carers

I interviewed two male and two female direct payment users in Bigtown. Two had physical impairments, one had a visual impairment and one had Huntington's disease. Like most of the users I met in Fletcherford, they turned to the state for only the help that families and friends could not provide:

'I have been in a wheelchair for 22 years. I never had any outside help until the wife became ill. She now has cancer of the spine. I do not get meals. Either my wife cooks or when she is ill neighbours and friends. I have got a 14 year old son. He will do messages and help with meals.' User

The three 'carers' were middle aged white women; two were married to the direct payment user. One carer was seriously ill and received care and support from the user. One user received a direct payment for her own needs, supported her disabled sister and worked as a volunteer at a luncheon

club for older people. This evidence of mutual dependency, between disabled people and their informal carers, mirrored the situation in Fletcherford.

By September 2001, when I began my interviews in Bigtown, there were 34 people using direct payments, one was over 65. Fifteen users had been receiving direct payments for more than a year. Twenty-eight direct payment users were identified by the support service as white; thirteen were male and 21 female.

Table 9.2 Direct payment users in Bigtown, identified by source of disability

Physical impairment	Visual Impairment	Terminal illness	Sensory +physical impairment	Learning difficulty
25	3	4	1	1

Between September 2001 and February 2002 the number of people receiving direct payments increased to 54, including three with learning disabilities, one older person and two with mental health problems, suggesting widening access.

9.2.4. The community care 'grapevine'

One obvious difference between the situations in the two areas was that in Bigtown care managers and services were spread over a large geographical area. In Fletcherford practitioner teams were located together in office bases focussed on three client 'specialisms'. In Bigtown specialist teams were located in six different 'patches'. In Fletcherford all the practitioners I interviewed knew the names of people who had expressed an interest in direct payments, and were observing the progress of their applications. In Bigtown practitioners did not have routine contact with colleagues in other areas, they were therefore limited in their opportunities to observe and discuss their experiences. This meant that practitioners did not follow the progress of applications for direct payments by people not on their own case-loads. They hear about the outcomes for individuals in other areas informally and so they did not have the opportunity to appreciate the practical implications of efforts to simplify and improve the scheme.

9.2.5. The planning phase of implementation

A small working group of key decision makers were involved in developing the Bigtown direct payments scheme, and initiating changes in response to recommendations from operational staff and users. This group was set up before New Labour's guidance (Dept of Health 2000a) strongly recommended the involvement of local users. It was composed of an assistant director, a finance officer, a council solicitor and the strategic planning manager. There was no user representation.

However in practice users had little influence over decision-making in the development of the direct payment scheme in Fletcherford.

I was only able to interview the strategic planning manager from this group. His account and those of the practitioners suggested that the 'corporate' experts and senior managers were enthusiastic about the initiative as a means of passing control to services users and recognising their expertise and insight. This was in contrast to the situation in Fletcherford. There, it seemed that the greater the distance that council officers were from users, in terms of both the organisational hierarchy and opportunities for personal contact, the more they were convinced that they were the best people to make decisions on their behalf.

Bigtown has a population more than seven times that of Fletcherford. The financial investment made by the smaller council into the development of the direct payment scheme was in relative terms not significantly disproportionate (£25,000 rather than £200,000), given the respective sizes of the two populations. However Bigtown social services made a much bigger commitment to staff training and raising public awareness. The scheme was regularly promoted in the local press. Posters and leaflets advertising the scheme were prominent in social services buildings. All care management staff received basic training on direct payments and quarterly bulletins advising them of the development of the scheme. Furthermore a senior practitioner from each area had additional training and was available to support individual practitioners and service users through the process of arranging direct payments.

The two lead officers from the strategic planning section remained involved in the introduction of direct payments in Bigtown, from the planning stage through the ongoing development and reviews of the scheme. They tried to resolve any problems practitioners experienced. These strategic staff were perceived as available and approachable and they remained in post long enough to win the confidence of those involved in the implementation of direct payments. They were supported by the consistent leadership of an assistant director.

Care managers and users praised the contributions of the senior staff involved in planning and facilitating the implementation and development of the direct payment scheme in Bigtown:

'Key people in the department have been very supportive, planning staff and an Assistant Director.' Senior Practitioner

This was in contrast to Fletcherford, where re-organisation and personnel changes meant a lack of consistency in leadership in the implementation of direct payments.

The initial procedures for arranging direct payments in Bigtown were changed in response to feedback from users, care managers and the support service.

'I got in touch with our planning department... they got their heads together to sort it out.'
Senior Practitioner

The support service co-ordinator felt that this explained the growth of the scheme after the first year, when only one person received a direct payment:

'Increased take up, the scheme itself has improved through feedback ... there is less bureaucracy.' Support service co-ordinator, February 2002

Care managers in Fletcherford however often commented that there was nobody in a planning role who understood practice issues and was capable of responding to their concerns, for example by changing procedures that proved cumbersome and obstructive. In Bigtown the extra training given to senior practitioners, to enable them to support inexperienced colleagues, was also appreciated. Practitioners did not feel that they had been left to implement another policy change without sufficient support and advice.

'One of the best things that happened in this area was having a principal case worker in each area as a focus and having planning staff staying involved with development at the centre. They are very helpful in dealing with issues.' Practitioner

9.2.6. Users as employers

Users in Bigtown who expressed an interest in direct payments were worried about becoming employers. They wanted to secure a relationship with a person they trusted.

9.2.6.1 The significance of the responsibilities of being an employer

Direct payments were calculated on the basis of hours of support in Bigtown. However they could be used to meet any need identified in the care plan so were not restricted to personal care only. The direct payment rate was based on the hourly pay for the council's home care staff, with employment costs added. This meant users were able to offer competitive wages in a way that they could not in Fletcherford.

Many users did not pursue their applications for direct payments, after an initial expression of interest. Practitioners largely attributed their withdrawal to concerns about being an employer. As in Fletcherford, users were said to be concerned about the responsibilities in the role, the extra work involved in the keeping records, dealing with tax and covering emergencies:

'They are worried about what being an employer means and making their own arrangements for cover. Filling in time sheets, paying bank holiday enhancements, it is daunting if you have never employed anyone before' Senior Practitioner

'I have had about twelve to fifteen expressions of interest, but few go forward. People were not prepared to take on the responsibility of appointing and employing someone. People are frightened despite the support service.' Senior Practitioner

However the strategic planning manager who monitored the development of direct payments centrally suggested that 'abortive' enquiries did not necessarily indicate a negative outcome. Of the one hundred people to enquire about the Bigtown scheme in the first two years, only twenty-eight ultimately switched to a direct payment. This senior manager observed that most of the others achieved what they regarded as improvements in their care plan, through discussing their needs and care packages with a care manager, without having to opt out of direct services provided by the local authority.

In Fletcherford the reduction in the council's own domiciliary services reinforced the conviction, held by many staff and service users, that disabled people and care workers were being abandoned to the mercies of a market dominated by profit motivated agencies through the implementation of community care policy. This encouraged some practitioners and disabled people to overcome their reluctance to pursue direct payments, although they implied extra work or responsibility. In Bigtown users and practitioners in home care felt the service was 'safe' and there was no suggestion that the council was reducing its commitment to be the major provider of social care. Practitioners cited high levels of satisfaction with current service arrangements as the reason that most users were not interested in direct payments.

'A lot feel safer with social services staff. There is still a big in-house service, people trust it.' Practitioner

Council services were also seen as an easy, safe choice for care managers in Bigtown.

'We would have to do it if it was the dominant model of care. Instead we still have a high percentage of in house services. Our homes and services are very popular.' Practitioner

However, as in Fletcherford, Bigtown users and staff expressed dissatisfaction about rigidities and priorities set in care plans by council service managers. One user had moved to direct payments having used in house home care for years. He had been happy with the staff but found the management practices and procedures they were obliged to work with were becoming increasingly inflexible. As practitioners explained, the council's concern to protect its workforce took priority over users' fairly modest aspirations for a 'normal' life:

'They have a lot of restrictions around health and safety, for example they cannot clean windows. We try to meet needs but not preferences. Also our staff can not bath people, they can only give a strip wash.' Practitioner

It seemed to some respondents that it was fear of change rather than faith in Bigtown council's services that deterred people from asking for direct payments. The council's services were reliable and their staff were trustworthy:

'Services are not brilliant but people fear breakdown if they make their own arrangements.' Practitioner

9.2.6.2 Relationships between direct payment users and personal assistants

As in Fletcherford, most disabled people who decided to pursue a direct payment in Bigtown did not do so because they want the power, responsibility and status implied in being an employer. Users wanted to protect a relationship with a care worker they trusted or to pay someone who already helped them voluntarily.

'People do not choose to be employers, they will only go on direct payments as a way of getting the other things, choice and control, but most drop out. People usually have someone in mind.' Practitioner

'My husband has been disabled since he was quite young, so we do not want strangers coming in. When the home carer is on holiday we do not know who we will get.' Carer

'I had the minister's wife working as my personal assistant... She was a friend who already helped me.' User

As in Fletcherford informal networks remained part of the package. Some people met and developed a relationship with their personal assistants when they worked for direct services. Unlike service users in Fletcherford they were able to offer a competitive hourly rate. However they were also concerned about the working conditions and security of their staff.

'I still worry about her giving up her job and think what if something happened to me?' User

Recruitment and retention of care staff was a problem nationally in both the independent and public sector during the period of this case study (Henwood 2001). Senior managers in Fletcherford were dubious about the ability of community care clients to employ suitable staff (chapter 7). However unlike the independent agencies that were criticised so heavily in Fletcherford for employing inexperienced and unskilled staff (chapters 6 and 8), direct payment users in both Bigtown and Fletcherford recruited personal assistants who had already demonstrated their suitability as either volunteers or employees.

9.2.7. Support for direct payment users

The support service in Bigtown was provided by council staff employed in a Resource Centre for Independent Living and was accountable to a management committee of disabled people. Two full time workers were initially employed to provide support to direct payment users. The Fletcherford support worker's fifteen hours were not proportionately less, relative to the respective sizes of the populations of the two communities. However the Bigtown support workers had the on site supervision of the Resource Centre manager and the support of administrative staff and others working alongside them in complementary roles. The part time support service worker in Fletcherford was not involved in an established network of services for local disabled people.

One user appreciated the efforts of the Bigtown centre to recruit from the local disabled community and to address needs holistically:

'At the resource centre there is a disabled people's help line and the direct payment support service. Most people who work there have disabilities. They also give welfare rights advice.' User

Additional support work time was purchased flexibly in Bigtown as the numbers of direct payment users increased. Users, carers and practitioners reported favourably on the support provided by the Resource Centre:

'Once he applied, the support service took over and were brilliant.' Practitioner

'If we need any help we can phone the support service co-ordinator, she is very good.' User

Being employed by the local authority and therefore not reliant on an annual round of contracting decisions was said by the manager to enable the support service staff to concentrate on supporting and advocating for users. Practitioners and users seemed to recognise that the 'permanence' of the support service implied that direct payments were a permanent addition to the local community care landscape, rather than short term experiment or 'another initiative'.

'Bigtown have made a commitment to support people who take on direct payments. There is a pay roll system, help with recruitment, advertising, and selection.' Practitioner

The Bigtown support service manager felt the security of being employed directly by the council made her more independent and more willing to challenge decisions on behalf of disabled people, than if she had been employed by a voluntary organisation. She suggested, from her experiences within the direct payments' regional and national networks, that in independent sector support schemes staff were often preoccupied with justifying their existence through numbers of referrals. Uncertainty over funding also made recruitment and retention difficult for voluntary sector schemes:

'There are lots of good people working hard, who want to provide a good service but they are always struggling to get money to survive. They do not want to get people relying on their services in case the funding stops.' Support service co-ordinator, February 2002

According to both the strategic planning manager and the support service co-ordinator, the users' management committee of the resource centre had considered becoming a charitable trust to receive grant aid from the council rather than mainstream funding for their services. However they had yet to be convinced of the advantages that 'independence' had over being part of the local authority's infrastructure, with the benefits of security, support and access to internal channels of communication.

Bigtown social services attempted to relieve direct payment users of one of the worries they commonly associated with becoming employers, by funding a voluntary sector payroll service, which all the users I met appreciated. Although the advice from the N.C.I.L. was that a payroll service was the type of assistance that direct payment users appreciated most, Fletcherford council did not include payroll support in its 'basic' direct payment scheme.

Care managers were encouraged to close cases following a review of the care package after six weeks in Fletcherford. In Bigtown practitioners working with older people said that they also needed to achieve a turnover in their case- loads in order to take new referrals. In both authorities the process of actually setting up a direct payment funded care package took months. In Bigtown where users had established relationships with practitioners, they tended to go to them first with problems with their packages. Two care managers reported that the support scheme helped set up direct payment packages and dealt with queries around finance, but that users turned to them with staffing and more personal problems.

'I get calls from people I never saw when they had a domiciliary package. They need ongoing support; there can be relationship difficulties with employees or even disciplinary matters. They could do with discussing how they handle them with other users.' Practitioner

I do not know if this was a subject of concern generally in Bigtown. However some practitioners when considering whether or not to suggest direct payments to particular individuals, in both towns, worried about acquiring additional responsibilities in supporting users in their roles as employers.

When I completed my fieldwork in Fletcherford in 2002 the support scheme worker had been left with the task of re-engaging local disabled people in the scheme, through setting up a 'peer support group'. As I argued in chapter 7, the aspiration for citizen participation had descended to the level of 'therapy', in terms of Arnstein's (1971) ladder of power sharing. Practitioners in Bigtown had hoped that a peer support group would enable direct payment users to discuss the problems they experienced (both emotional and practical) with other people in similar situations. They felt that there was a need to replace the 'therapeutic' aspects of their relationships with users that the demands of care management had largely removed from their practice. However no users responded to attempts to establish a peer support group, apparently preferring to seek individual assistance from either the support service or their social workers.

*'We are not involved in any groups. I have enough going on in my own home and fighting my own corner...
I speak to the social worker by phone most weeks and she visits fortnightly. Not lots of problems it's just nice to see her.'* Carer

'I do not need any peer support I just ring the resource centre or I can just go down..' User

The users and carers I met in Bigtown did not have contact with other people using direct payments or community care services. The 'grapevine' of communication amongst informal networks was much stronger in Fletcherford. Notwithstanding the difficulties disabled people and carers often had in attending meetings and the additional transport problems in the larger town, it was hard to see that direct payment users would be any more interested in a peer support group in Fletcherford than they were in Bigtown.

Despite the help provided through the support and payroll services, Bigtown strategic planners were considering setting up a 'personal assistance' scheme, using staff employed directly by the council. This was in response to suggestions from practitioners that many users wanted to manage their own care without employing staff directly. Bigtown social services recognised that direct payments were not the only way that users could gain more control over their care arrangements and lifestyles. The larger authority probably had more capacity for running two schemes than Fletcherford. It is

noteworthy that this traditional Labour authority planned to employ personal assistants directly, rather than commissioning an independent organisation to run a scheme.

9.3. Who gets direct payments?

There were similarities and differences in the characteristics of the people who used direct payments in Bigtown and Fletcherford.

9.3.1. Capacity and Consent

In keeping with the national trends in 2001 (Dept of Health Autumn returns, 2001) the relative take up for some populations in Bigtown (people with physical and sensory impairments) was higher than for others (mental health service users, older people, people with learning difficulties and people from the ethnic minority). I did not have access to a representative sample of community care users or practitioners from various 'client specialisms', however I was able to uncover some contrasts with the treatment of people with intellectual impairments in Fletcherford.

Bigtown introduced direct payments before the New Labour government's revised guidance (Dept. of Health 2000a) relaxed the 'able and willing' criteria, that had allowed councils to exclude people who could not demonstrate the capacity to manage and to consent to receiving cash in lieu of care. However capacity and consent issues were not identified as obstacles to some people getting direct payments, unlike in Fletcherford. It seemed that they arose occasionally in Bigtown but were addressed through tailoring the assistance offered to meet individual needs for support as recommended in the 2000 guidance. This was an example of local policy and practice developing through implementation. It was then supported by changes in central government's guidance, in response to experience 'at the bottom'.

'We have had capacity and consent issues, we recognised people go at different speeds and need different sorts of support. All our work is with individuals.' Support service co-ordinator, February 2002

Use of direct payments by people with learning difficulties in Bigtown increased, as social services began to implement the *Valuing People* White Paper (Dept of Health 2001).

'In the first two years we had only one person with a learning disability, now we have six...including three in process.' Support service co-ordinator, February 2002

There were other potential reasons for impaired capacity

'His lack of co-ordination and rapid deterioration because of his condition (Huntingdon's disease) were not a problem with Bigtown Social Services, there was no argument over his ability to manage direct payments.' Carer

In Bigtown it appeared that the assessment of the individual's capacity to manage and consent to receiving a direct payment was left with the care manager. She could draw on the clinical expertise of other practitioners where she judged it was necessary, just like in situations where direct services were arranged for a person who could not clearly express their preferences. I found no example of managers referring the issue of an individual's capacity to the council's legal department for 'advice'.

In dealing with capacity issues practitioners assessed the individual's needs and circumstances holistically, taking into account whether the person could manage direct payments with support and whether this support would be available, from both formal services and informal networks. A man whose capacity was impaired by Huntingdon's disease was assessed as able to manage a direct payment with the support of his (nurse) wife. A young man with learning difficulties was assessed as able to manage a direct payment with the support of his (social worker) father. In each case the preparation and assistance provided by the support scheme was tailored to the needs of the individual in the family situation.

In contrast the first and only person with learning difficulties to request a direct payment in Fletcherford, was refused on the advice of the council's solicitor. This decision conflicted with the social worker's assessment that took into account that the young man's father was already helping him to manage his benefits and his direct payment from the Independent Living Fund. However the carer's employment status did not afford him the cultural or symbolic capital of a nurse or social worker. Greener's (2002) analysis would suggest that differences in knowledge and professional status might affect the treatment individuals receive from public service actors and might counter or reinforce the influence of a 'care discourse' (Morris 1993).

9.3.2. Reflexivity and Risk Aversion

In Bigtown the direct payment scheme was publicised regularly, while in the smaller town a 'low key' approach was preferred. Nevertheless practitioners in Bigtown suggested that information about the community care system was not equitably distributed within communities and that knowledge itself empowered some people to pursue direct payments as an option:

'The father was a social worker, so he has insider connections and knowledge that helped the .' Practitioner

Links with and the support of disabled peoples' organisations were also identified as significant but it was not possible to conclude whether this involvement was a cause or an effect of individuals being confident and well informed:

'I have one lady on direct payments. She was on the committee involved in introducing it. Active in disability rights, uses a computer to get information.' Practitioner

Users, carers and practitioners, like their peers in Fletcherford, argued that some people were more assertive, and so were more able to get what they wanted from the community care system. Others were told what they were 'allowed'. This in turn seems to have influenced whether they expected direct payments to improve their situation or just give them more stress without necessarily giving them more control. Experiences in both towns thus lend support to Barron's (2001) conclusions that the move towards individually empowering initiatives benefits some disabled people but disadvantages others.

'It is quite self-selecting. It is people who feel they can cope, not everyone thinks they can.' Practitioner

'People I know find it very difficult to make a choice because they have never been given the opportunity. With 'shared care', some organise their own respite directly, others need their social workers to organise it for them. Other ways to empower people would be improving social skills, assertiveness and confidence.' Practitioner

9.4. Bigtown : an Alternative Approach?

There were issues identified as obstacles to the success of direct payments in Fletcherford, in terms of both numbers and experiences of users, which did not seem to be of major concern in Bigtown. Users and carers in Fletcherford who had managed to get a direct payment said they had benefited, although they would have preferred more flexibility in their care plans. They were critical of the bureaucracy they had to deal with both to get direct payments initially and to account for their use. Payment rates, unexplained delays in processing applications and inflexible rules about which services could be converted to a direct payment were all sources of frustration to the few direct payment users who had managed to survive the system in Fletcherford and the reason many had withdrawn.

9.4.1 Payment system

The system for making direct payments in Bigtown was designed to simplify budget management for users. The regular payments covered hourly wages and National Insurance contributions.

However additional costs were reimbursed separately when expenditure was incurred. In contrast the Fletcherford scheme used a single 'rolled up price' formula (a set rate per hour of care needed), requiring users to plan and budget for holidays, sickness and emergency cover. The negative aspect of the simpler approach for users in Bigtown was that care managers were responsible for calculating how much individuals should receive. Senior practitioners suggested that some found this flexibility in building up the budget threatening:

'The sticking point is often grasping how you translate a statement of need into a sum of money, people can not cope with and understand that.' Senior practitioner, September 2001

One experienced worker suggested that the responsiveness shown by strategic managers responsible for introducing the scheme was itself a problem in Bigtown because practitioners could not keep up with changes.

9.4.2 Arranging direct payments in Bigtown

The users and carers I interviewed in Bigtown all said that they would recommend the direct payments option to other people. However like their Fletcherford peers, the early applicants suggested that it had taken too long to arrange their first payment. They blamed 'teething troubles' with the new scheme. Care managers also felt that as the scheme became established, arranging direct payments would become a matter of routine and good practice.

'I was the first from our team. I hit barriers they may have sorted out by now'
Practitioner

Those responsible for developing the Bigtown scheme had, as in Fletcherford, been concerned at first that it would be overwhelmed with applicants and had focussed on 'getting it right' for the first few applicants. Procedures were changed as problems were identified through the experiences of the first users. When it became apparent that people were waiting too long and that this was causing frustration the process was accelerated.

'The scheme wanted people processed one at a time, it was very slow, only one through in the first year. We recognised that people take different times, to reach a decision, to understand.' Support service co-ordinator, February 2002

Unfortunately by 2001 many practitioners had only indirect experience of direct payments in Bigtown and they remembered the negative accounts of colleagues involved in the initial stage of the scheme, when problems causing delays had still to be resolved.

9.4.3 Monitoring

Monitoring documentation and procedures have been criticised as an extra source of stress and confusion for people who receive direct payments (Pearson, 2000). In Bigtown no one complained about monitoring arrangements or systems for accounting for the use of care funds. Users were asked to keep records but the council carried out periodic audits of a sample only.

In Fletcherford direct payment users complained that they were being asked for staff time sheets as well as providing monthly returns of expenditure, evidenced by bank statements. This was not only an extra responsibility for users but created an extra demand on the limited time of the support service worker.

Practitioners in Bigtown supported the general view of their peers in Fletcherford that direct payments offered no more opportunities for abuse than other care arrangements. They were therefore not in favour of either rigorous monitoring or highly specified care plans:

' We have got to take risks if we are giving them choice. We should not be telling them what is right. There is a risk of abuse for older people but we have that now. There is not a greater risk with direct payments. ' Practitioner

9.5. The Opinions and Influence of Practitioners

Practitioners played a key role in the implementation of community care policy in both towns.

9.5.1. Practitioners' perception of direct payments as difficult and time consuming

Despite the investment in training and support, the general impression I was given by practitioners in Bigtown was that arranging a direct payment package for a community care user was a very difficult and time consuming process. This was partly because direct payments were new and practitioners were unfamiliar with the process, but also because of the experiences of early pioneers amongst care managers. Some admitted that they were sometimes reluctant to pursue this option with their clients because they felt their own lack of confidence and knowledge would deter people worried about assuming additional responsibilities. This hesitance did not seem to reflect any lack of commitment to the principles of direct payments:

' My only worry is that it is not easy to set up. The idea is brilliant but not easy. Because it appears to be complicated to us and users, it takes a lot of work to get it off the ground. ' Practitioner

This negative perception was not shared by the users and carers who were already receiving direct payments, or by the support service in Bigtown. However the opinion that arranging a direct payment was onerous for care managers, echoed that expressed by practitioners in Fletcherford, including those who had no experience of dealing with an application. Similarly, some Bigtown practitioners also said that the issue of direct payments had slipped from their consciousness after the initial training and publicity. That was because they were too pre-occupied with what they understood as the core care management tasks:

'With care management we had to get our heads around contracting et cetera. With this it is an optional extra.' Practitioner

People with experience of direct payments in Bigtown commented that the process of arranging a direct payment had been simplified as strategic planners became aware of the difficulties experienced implementing new procedures. However many practitioners with no first hand experience, had the impression that the process was still complicated and laborious. This may have made them reluctant to promote direct payments or to respond with confidence and enthusiasm to individual enquiries. This boded ill for Fletcherford, where in 2002 there was no indication that council decision makers were inclined to simplify the process for arranging direct payments.

9.5.2. Community care policy and New Labour's modernisation plans.

Practitioners' understanding of the values underpinning and the philosophical objectives of policy initiatives usually affected the way they interpreted guidance and exercised judgement in the implementation process.

Like their peers in Fletcherford, Bigtown care managers believed that the community care policy introduced by Conservative governments had been ideologically motivated. Any benefits to social care users had been incidental to the objective of undermining public services and saving money. Feelings were more mixed about New Labour's modernisation plans and the government's promotion of direct payments. Practitioners in Bigtown were apparently more aware of the role played by the disability rights movement in the introduction of direct payments.

'It was not their idea, it was the disability movement. I can see how the Tories would latch onto it to reduce public services.' Practitioner

Some were cynical about policy initiatives that were politically motivated and questioned whether Bigtown council had responded to 'top down' pressure rather than the wishes of more than a small number of local people in introducing direct payments. In Fletcherford practitioners felt that while

there would be a local interest in direct payments, lack of awareness of the possibility amongst local disabled people meant that it had been left to the government to promote the initiative. One very experienced social worker in Bigtown suggested that the objectives of policy makers usually proved to be irrelevant to the outcomes of policy implementation

'I do not know whether policy makers thought it through, over twenty years I have found they usually have not..... I do not worry about policy change because so much can happen before it trickles down to the front line.' Senior Practitioner

9.5.3. 'Street level bureaucracy' in interactions between practitioners and citizens

As in Fletcherford, the accounts of disabled people and practitioners in Bigtown confirmed that the latter exercised discretion in their implementation of community care policy. This was particularly in the areas of resource rationing and eligibility criteria that they felt undermined the principles and objectives of independent living. The more skilled and confident practitioners were able to circumvent rules and restrictions in the interpretation of need in assessments. Practitioners described how funding issues highlighted the conflict for them in their roles as advocates for individuals and gate-keepers for council resources. Users were sometimes aware of the struggles between practitioners and managers over resource rationing:

'I was offered five hours at first by my social worker but then it was cut to four by the manager.' User

It was not only care management staff who exercised discretion to help meet 'need' not officially recognised by the council's eligibility criteria:

'...because I have a direct payments package I am not officially supposed to go to the day centre but the staff let me use it as a drop in ...' User

Like their peers in Fletcherford practitioners suggested that where budgets are rationed, direct payments can enable users to get better value from the funds available by choosing priorities and buying services of an appropriate quality.

'If someone is in control, it is their choice... We are restricted by budget holders' control. We are on the front line, in a difficult position. People tend to think social workers have not done their jobs well enough, but we have.' Practitioner

In both areas, practitioners sometimes assessed needs the user had not identified

'They said I can get more if I need it. Originally it was social services that said half an hour each morning. It takes them that to get me ready because of my quadriplegia.... The social worker said I needed an hour at night or it was not worth them coming down.' User

Practitioners in Bigtown, like their Fletcherford peers, felt ethical dilemmas in implementing eligibility criteria and charging policies. They resented being involved in charges and resource rationing:

'The welfare state was devised to help people who have not got money. It goes against the grain to ration. You would not do the job if you did not want them to have what they need. I am torn as to whether people who have the money should pay. I do not like it, I feel they are entitled.' Practitioner

One practitioner described how even more assertive clients are subject to the social worker's attitude, understanding and confidence:

'I have got two very politicised disabled women. They raised issues for me as the assessor in how to respond, balancing their rights and SSD resources. Users are very dependent on the social worker and her attitude. We have control. We can really limit what they get in the way we write the care plan.' Senior Practitioner

As in Fletcherford, practitioners exaggerated need in assessments in anticipation of resistance from budget managers:

'The whole thing is difficult. It is like playing God. What I do every time is ask for more than they need and end up with less. It depends how you fill in the form.' Practitioner

The ability and willingness of council officers to use their judgement in the interpretation of policy seemed crucial to the success of direct payments in Bigtown. Senior managers used discretion in allowing a direct payment user to employ his wife, when the social worker argued that she could meet his needs most appropriately. Most practitioners chose not to question the competence and motivation of people requesting direct payments or to challenge their plans. One person had complex needs of an order that merited regular admissions to a health facility; however his social worker did not attempt to distinguish his health care from his social care needs for the purpose of calculating a direct payment.

The view of the support service co-ordinator confirmed the central role of practitioners in enabling people to access and fully benefit from direct payments.

'No matter what we think about social workers, they are the key people in doing care plans. A lot of very good social workers, put forward very creative ideas. Occasionally an individual social worker or a team always finds problems. Social workers' confidence varies...' Support service co-ordinator

In Bigtown three of the users and two of the carers I spoke to were keen to give credit to the role played by practitioners in helping them to get and make full use of their direct payments.

'I would die if the social worker left, she has fought for us tooth and nail.'
Carer

However one person's experience lent support to Barron's (2001) thesis about alternative approaches to the exercise of power over disabled people:

'They come in and try to tell him what is best for him. They do not look at things from a disabled person's point of view.' Carer

9.5.4. Direct payments and health

In Bigtown only one practitioner interviewed was in favour of direct payments being made available to meet health care needs, because it would give social services clients the privilege enjoyed by the well off:

'It is already there for people with money, why should our people not have the choice?'
Practitioner

One had mixed feelings

'If it gets you what you want at an appropriate time like more physiotherapy it sounds okay. But I worry about a two tier system being immoral.' Senior Practitioner,

The other eleven clearly put collective interests and social justice before individual rights. Like the majority practitioners in Fletcherford, who opposed the use of direct payments for health needs, they felt that the introduction of money into the delivery of health care to individuals would somehow undermine or corrupt the system.

'It is dangerous to blur the boundaries between health and social care, politically and practically.' Senior Practitioner

'If it is part of the NHS, it should stay with the NHS. Money should not come into it.'
Practitioner

Despite their strong expression of principles, I found no evidence in either town that care managers in practice let the apparently hallowed 'boundary' between health and social services prevent individuals from getting the care arrangements they preferred. One of the Bigtown direct payment users appeared to have both health and social care needs. His social worker used this to argue the case for allowing him to employ his wife, a qualified nurse, to provide care. However there appeared to be no attempt to reduce the funding contribution from the council's community care budget to account for the health care elements of his care package. Instead of cost shunting between the statutory funders, it seemed that health and social work practitioners collaborated to use the complexity of this person's needs to meet the family's preferences despite the scarcity of resources:

'He still goes into a health bed for respite. Officially he is admitted with 'chest infections'.... They have only so many beds and they are in such demand.' Carer

9.6. Concluding Discussion

Bigtown was a 'traditional' Labour council that showed its preference for public sector provision by continuing to dominate the 'mixed economy' in community care, by providing support for direct payment users directly and by planning to set up an 'in-house' personal assistance scheme. The authority nevertheless used an independent organisation for the initial consultation on direct payments and acted on its recommendations. Bigtown council attempted to engage the whole potential user population in an impartial consultation exercise before the New Labour guidance recommended user involvement so strongly. It probably achieved more meaningful participation than Fletcherford's very limited and selective consultation and its tokenistic involvement of users in the development of the scheme.

Direct services were popular in Bigtown and there seems to have been no suspicion when strategic planners in social services broached the subject of direct payments, that this was an attempt at back-door privatisation. A small group of users and staff at the local resource centre, provided 'bottom - up' pressure in support of the initiative and one carer wrote to the director of social services requesting a direct payment. This may have helped convince councillors that direct payments were a rights issue for disabled people and not another 'consumerist strategy'. If this was the case, the actions of about seven people from a population of over 700,000 were enough to persuade council leaders to commission an independent consultation. In Fletcherford practitioners' reports of requests for direct payments from individual service users appear not to have been relayed by managers to politicians before February 2000.

Strong support at the senior management and political level, including from the council's legal and financial services, seems to have empowered those leading the implementation process to respond flexibly to issues identified through practice. They were not required to go through the process of presenting the case for every revision of local policy and procedures to senior managers and councillors. In contrast, in Fletcherford planning staff had convinced councillors at the outset that there was little interest from local people in direct payments. They therefore invested little commitment to introducing the initiative in response to what they thought was 'top-down' pressure from a central government determined to secure co-operation in pursuit of its own policy objectives irrespective of local opinion.

From May 2000 there was no single party running Fletcherford with its own policy programme. Therefore the only political leadership and interest in direct payments came from central government filtered through a system of inspection and performance monitoring. New councillors in key roles in Fletcherford had little knowledge of community care or disability rights issues and did not have time to develop their awareness of direct payments to influence their development during the implementation period.

In Bigtown, the support service staff and management committee felt empowered rather than compromised by their position within the local authority's service infrastructure. They challenged procedures they perceived as obstructive and contributed to the development of the scheme. The security of their public sector status and funding seemed to offer reassurance to practitioners and potential users that the council intended that direct payments should become a permanent feature of the community care landscape. In Fletcherford however the support service manager was aware that continued funding for her service, from year to year, relied on satisfying the priorities of those in the council with power and influence over contracting decisions. Also as an 'outside' agency, the organisation providing support did not have the backing of the local voluntary sector and the disabled community. This may explain why the manager was reluctant to openly challenge key decision makers, although she agreed with the planning manager and operational staff that the local policies and procedures deterred many people from requesting direct payments and restricted their potential benefits for those who did.

Officers in influential positions, who wanted to limit the impact of direct payments in Fletcherford, could prevent those involved in implementation from revising local policies and procedures in the light of experience. Development was left to practitioners using their knowledge of people's needs, preferences and circumstances and their discretionary power as 'street level bureaucrats'. Senior managers in Bigtown seemed not to be swayed by a 'care discourse' (Morris 1993) that portrayed service users as unable to manage their own care arrangements, despite its fairly unbroken tradition of municipal paternalism and the campaigning activities of local disabled people using the resource centre were probably influential. In Fletcherford, key actors resisted the challenge to their own expertise presented by a policy programme that demanded responsible action from care recipients, in contrast to their traditional treatment as passive-'pawns' (Le Grand 1997). It seemed senior officers and corporate experts could wield more power in an authority run by a relatively inexperienced coalition of minority party councillors than one run by an established and experienced party group with a large majority. This might have been the case whichever party held overall control.

Practitioners in Bigtown found that senior managers and politicians were more receptive to suggestions for increasing the potential impact of direct payments. They sometimes found the extent of their delegated power and responsibility in implementation intimidating, mainly because they felt they lacked financial expertise.

Experience in Bigtown suggests that even if the system for arranging and accessing direct payments in Fletcherford is eventually streamlined, the impression that the direct payments involve extra work and frustration for practitioners and stress, and delays for potential users, will have entered the local community care culture.

Despite the greater investment in publicity and promotion in Bigtown, practitioners were also gate keepers to information about direct payments for most potential users who did not have links with disability rights or community care networks. They seemed no less willing than their peers in Fletcherford to use their position and discretion on the frontline of service delivery, to interpret community care policies and procedures to prioritise the interests of their clients over political or economic considerations. Practitioners in both authorities justified their deliberate manipulation of national and local guidance by reference to the ultimate objectives of contemporary social policy and the values and principles that underpinned their practice.

In both areas there were some service users who appreciated the opportunity offered by direct payments to achieve more control and flexibility in their care arrangements. They wanted to choose who provided care for them, at what times and in what manner. The tasks involved were of an intimate and essential nature and the individuals were vulnerable, given that they were expected to entrust their physical care and access to their homes to care staff. Their aspirations were therefore fairly modest and concerned with meeting their basic human needs for survival, safety and dignity (Doyal and Gough 1993). Disabled people in Bigtown and Fletcherford did not seek a direct payment because they wanted the status of being employers or to exercise power over the staff who provided their care. Instead they wanted to secure a relationship with people they could trust and to share 'power' with them, in the form of control and flexibility in working arrangements.

In Bigtown users were less motivated than people in Fletcherford by the desire to improve the lot of their staff. However secure, reasonably well paid employment in the council's own services was still available for staff who chose it, unlike in Fletcherford where independent sector agencies offering the minimum wage dominated. While there was not the same motivation to remedy the

social injustices of the community care labour market, disabled people in Bigtown were still concerned about staff conditions and security.

Users in both Bigtown and Fletcherford sought help to fill the gaps in their care arrangements that family and friends could not cover. They tended to underplay rather than exaggerate their needs and valued the 'independence' of the self-sufficiency promoted by New Labour's policies (Dept of Health 1998a, Vernon and Qureshi 2000), as well as the 'independence' of self-determination promoted by the disability rights movement (Morris, 1993). Direct payments enabled Bigtown users to pay people who were providing support voluntarily. As in Fletcherford, users were usually at least as successful as statutory and independent care providers in recruiting and retaining suitable staff, even though they could not offer the career progression, professional supervision and peer support that big organisations could. Familiarity, mutual respect and trust were the most important resources available to disabled people in both towns. Community-care policies and practices that nurtured relationships and reciprocity promised to combine public and private resources cost effectively and to meet the needs and preferences of both users and staff.

It was not possible to generalise about the majority of community care service users in both towns who did not request a direct payment. It seems likely that significant numbers of people requiring care did not know about direct payments so could not express interest if the option was not offered by care managers. Perceptions of the adequacy and appropriateness of the support on offer affected individuals' attitude to direct payments. However, notwithstanding the differences in the approach to promotion and support between the two authorities, it seems that in both towns there were disabled people who did not relish the 'risks' and the responsibilities involved in managing their own care packages. As the literature suggested (Greener 2002, Hogget 2001 Taylor-Gooby 2001), past experience, as well as their social and economic situation, influenced people's expectations and provided the 'context' in which ideas and opportunities were introduced to them. This included their experience of their relationship with the council and its staff. In Fletcherford people had experienced the implementation of 'policy initiatives' associated with community care as leading to a reduction in the availability and quality of services overall and the withdrawal of council own services. In Bigtown, service users generally appreciated the major role played by council services in community care provision and trusted that they would be there to serve them. In both situations it seems that many people were reluctant to risk giving up their familiar care arrangements to become employers and /or to buy and budget for their own care.

Findings from Bigtown show that the behaviour, motivation and expectations of disabled people and social work practitioners in Fletcherford were not 'untypical' but had outcomes specific to the

particular conditions and circumstances. They support Pawson and Tilley's (1997) thesis that policy actors have 'powers and liabilities' which allow them to accept or resist change and that policy programs are embedded within a wider set of 'macro' and 'micro' forces, so that the impact of policy change is contingent upon the context. Experiences in both Fletcherford and Bigtown therefore have wider relevance to understanding the implementation of the community care policy of the Conservative governments and New Labour's efforts to achieve greater success in the achievement of policy objectives, as exemplified through the extension of direct payments.

CHAPTER TEN

Conclusions : Still 'Muddling Through'

'Deliberate, orderly steps therefore are not an adequate portrayal of how the policy process actually works. Policy-making is instead a complexly interactive process without beginning or end.' Lindblom and Woodhouse (1993,11)

10.0 Introduction

The case study of the policy action process began with an exploration of the relationship between the national policy programme and the wider social, political and economic context, as presented by the actors responsible for its formulation. That is the Blair government. To follow the implementation process through the policy -action chain required an understanding of the national and local context for the initiative and the meanings the various actors gave to their expectations and experiences. The research showed how actions were taken on the basis of decisions people made from the choices they perceived were available to them. Those choices were contingent upon both the context, and what Pawson and Tilley (1997, 50) called the 'powers and liabilities' of individuals:

'Social programs are the product of volition, skilled action and negotiation by human agents and are not reducible to the facticity of a given event.'

First the findings from this case study are discussed in relation to the research questions posed and the literature reviewed earlier. The interaction between contexts and mechanisms in the two authorities are presented next and the outcomes compared. The lessons from the case study are then identified. I conclude the chapter by specifying the contribution of my study with reference to the main sources and theories tested through my research.

10.1 The Research Questions

1. *Was the central government's approach to policy making clear and coherent within its modernisation programme and what were the implications for implementation?*

There was evidence of consistency across government policy documents with the reasons given for the policy initiative (theories) and the objectives (ends) identified. However weaknesses in 'joined up thinking' at central government level were reflected in the guidance on how policy objectives were to be achieved (means) that had negative implications for the implementation of direct payments in Fletcherford. This lends support to the 'statutory coherence thesis' of Meier and McFarlane (1996). They asserted that successful policy initiatives require coherent statutes, with precise goals supported by an adequate causal theory, and clear rules and responsibilities for implementation assigned to committed agencies.

The New Labour government chose to develop direct payments from the starting point of the Conservative government's community care arrangements, supporting the 'unfinished business' thesis of Clarke and colleagues (2000), that Blair's government's modernisation programme was intended to remedy design flaws in its predecessor's policy. Despite the minister's evident interest in promoting the rights of disabled people (5.3.1) and the government's concern to extend the use of direct payments (Dept of Health 2000a), the obligation to implement direct payments was introduced gradually, within the selective, residualist model of community care policy. Councils were delegated responsibility for policy decisions in implementation and left with considerable discretion in designing local schemes and in promoting or restricting access. Practitioners were left to negotiate and interpret local eligibility criteria to the detriment or advantage of particular users. New Labour's approach to direct payments, within a programme of targeting welfare selectively, did not conflict with the analysis that overall their social policy programme represented a *'fundamental shift further towards a residual safety net model'*. (Lister 2001, 434) Blair's government did not promote or recognise collective or universal approaches. Consistent with its 'supply side' economic strategies (Jessop 1994, Jordan 1999, Levitas 2001, Lister 1998) only income from earnings was exempted from means testing.

Fundamental issues were left to be resolved at the local level in implementation. Values interfered with pragmatism at both the government and 'street level'. Tensions, between the collectivism associated with traditional 'old' Labour values and the individualism of the 'New Right' reforms of public services that the Blair government inherited, were not easily resolved through New Labour pragmatism. The account provided by the minister and a leading civil servant (5.3.5.) illustrated that there was reluctance at the political level to undermine the collective nature of the 'health service'. Most practitioners (9.5.4.) were also reluctant to accept the potential break up of this valued collective provision by the 'commodification' of health care and the introduction of commercial considerations to practitioner-patient relationships. Practitioners were also conscious of the principles of universal access to health care that they perceived were threatened by increased charging in the selective provision of the personal social services.

Experiences of actors in the case study (8.6.7 and 9.5.4) confirmed what research (Glendinning 1998, Rummery and Glendinning 1999) and case law (*R v North Devon Health Authority ex parte Coughlan*, 1999) suggested. The distinction between health and social care is a social construct. Thus the boundary between them has been repeatedly redrawn since the separation of the two types of public sector provision in the 1948 National Health Service and National Assistance Acts. The imperatives for moving this boundary have been political rather than clinical and have meant that

'health care' has remained universally available and free at the point of use, based on accountability to a national electorate. In contrast 'social care' has been provided on an increasingly selective basis (Dept. of Health 1998a, 2.6) with the free services of informal carers (Dept. of Health 1998a, 2.2) and means tested charges of growing significance (Audit Commission, 1999, 2000). Some activities that were once recognised as health provision in community care has become the responsibility of social services, subject to local accountability, rather than a right of citizenship as Rummery and Gledinning (1999) found. Nevertheless it seemed that for many policy actors in this study, from politicians and civil servants to practitioners and citizens, the National Health Service was revered as the embodiment of the collective values on which the welfare state was founded. Political decision-makers wanted to preserve the cultural icon of the N.H.S. and to support the 'universal altruism' it symbolised. It was left to practitioners, users and carers to try and fill the gaps between 'health' and 'social care' provision in the community. Health and social care were therefore also re-defined in interactions between street level bureaucrats and citizens. Practitioners were concerned to get the service arrangements most suited to the needs, preferences and circumstances of individuals including, direct payments, irrespective of the funding responsibilities and eligibility criteria of the respective agencies. They assessed needs as 'health' or 'social' care accordingly.

Lack of clear direction allowed decision-making in implementation that was inconsistent with the government's acceptance of market theory as a guide to pragmatic action (Dept. of health 1998a). The pay and conditions of care staff were another aspect of the minister's continuing concern with social justice, the traditional end of social policy that the New Labour government was seeking to achieve by 'modern means' (5.3.1.). He recognised the threat posed by the move from collective to individualised services in community care. Nevertheless he prioritised the rights of individuals over the interests of their staff, extending user choice over protecting social care services (5.3.1.) The expectation was that direct payments would enable users to manage budgets cost effectively based on their own preferences (Dept of Health 2000a, 3: 2) and to negotiate terms and conditions with their employees. However the policy guidance did not address this clearly and only said that direct payment arrangements should be tested for 'best value'. There were ambiguities in the 'Fair Access to Care' Guidance (Dept of Health 2001) about whether the government was promoting equality in access or outcomes. This confusion about the means and ends of this policy allowed local authorities to set rates for and attach conditions to direct payments, based on their own preferred interpretation of the criteria of 'best value' and 'fair access' (7.7.1, 7.7.2. and 9.4.1). The impact on implementation was to limit the choices available to service users in Fletcherford, to undermine the

principles of market theory and the pragmatic use of the market (Smith 1961, Le Grand 1993, Barlett 1998).

2. What were the implications of central government approach to achieving of its policy objectives by delegating responsibility for implementation to local authorities?

There was a deliberate strategy by the civil servants developing the direct payments guidance to allow practice to inform further policy development. This was exemplified by the rather ambiguous early guidance (Dept of Health 2000a) on the use of direct payments for health care, which the above discussion suggests was a matter of ideological conflict that could not be resolved initially at the national political level. It allowed local schemes, practitioners and users to identify problems that were addressed by later guidance (Dept of Health 2002a) as part of the government's 'gradualist' approach to securing the compliance of the lower tier of government. Policy was thus developed through the implementation process. The accounts of civil servants (5.3.5. and 8.6.7.) indicated that gaps were left to be filled by 'bottom up' influence. These accounts were consistent with Hjern and Porter's (1997) analysis of 'policy sub-systems', through which lower level actors make and develop policy through conflict and negotiation during implementation.

The Blair government sought compliance through the use of centralised performance management systems (Dept of Health 1998, 2.34). They had a counter-productive effect on the implementation of the initiative in Fletcherford, in terms of wider policy objectives. Senior managers felt under pressure to produce a 'direct payment scheme' to show progress to the Department of Health. In their eagerness to get a 'basic scheme up and running' (7.2.3.) they neglected the opportunities to use the processes of planning and developing direct payments locally in pursuit of other goals, in particular the building of capacity in individuals and communities through genuine participation. Similarly the focus on demonstrating the achievement of the performance target of offering direct payments meant that attention was diverted from the ultimate policy objectives: promoting independence, choice and control for disabled people. Therefore the 'means' to that end were developed in such away that limited the choice and control offered to disabled people. The empowering potential of direct payments was undermined by the government's approach to performance management and the use of crude output indicators.

This evidence of the impact of centralised performance management in promoting a narrow and short-term focus on measurable, intermediate objectives in this study supports Hunter's (2001) critique, the conclusions of Newman's (2001) review of the research and McKeivitt and Lawton's (1996) findings. There was also evidence (8.4. and 8.6.6.) to support Lawton's contention that

there are opportunities in the conflict between professional and managerial goals in public services, to protect and promote the interests of users through the alliances of weaker stakeholders. As Newman (2001) predicted, it proved possible for managers, professionals and user groups to appropriate parts of New Labour's own 'modernising' discourse in their pursuit of other interests and agendas.

3. How did political ideology, interests and alliances shape policy formulation and implementation at the local authority level and how were tensions between policy objectives reconciled?

Comparison between the attitudes and actions of politicians in the two authorities provided a contrast, even though when direct payments were introduced as a local policy issue both had Labour councils. In Priestley's (1999) research, the imposition of a competitive 'contract culture' on a Labour authority had threatened the collective nature of an 'indirect payments' scheme that had been developed by local disabled people working co-operatively with council support. Pearson (2000) described how a Labour authority had constrained the development of its direct payments scheme to protect council jobs.

In Fletcherford the councillors had been obliged to embrace the market pragmatically in response to economic pressures that threatened the loss of jobs and services. The ideological conflict implied was played out in political conflict within the Labour group. Service users and representatives of voluntary groups regarded direct payments suspiciously when presented as a Conservative government policy, because their recent experience of the impact of community care had been so negative (5.2). Councillors perceived no genuine local interest in direct payments and invested little financial and political support in implementation (5.3). Officers who had little insight into users' experiences and preferences in community care colluded with those who remained ideologically opposed to direct payments as a New Labour initiative. They exploited political and historical contextual conditions to prevent direct payments having a major impact on community care arrangements in Fletcherford (7.7.).

In Bigtown however, the council had managed to maintain its role as the major provider of community care services and neither politicians nor users automatically saw any Conservative government policy with a 'consumerist' focus as a threat. Bigtown councillors believed that direct payments had the support of the local disabled community and invested funding and political support in developing and promoting the initiative (9.2.). Officers in leading roles supported the initiative and remained in post long enough for that support to be translated into practical help for practitioners and users in resolving early problems in implementation (9.2.5.). Politicians in both

towns hoped that direct payments would give service users opportunities to raise the quality of their own care arrangements above the low standards provided through the community care market (5.3.3. and 9.2.2.).

In Fletcherford operational managers were fully occupied in both running existing services and in implementing the whole 'modernisation' programme. The workload overall meant that they were unable to devote equal effort to everything demanded of them. They therefore chose their own priorities when rationing their own and their staffs' resources and thus resolved tensions between policy objectives. The intermediate objective of achieving 'turnover' in referrals through processing 'cases' quickly, for example, was prioritised over the ultimate objective of developing care arrangements that would promote the independence of individuals. Therefore because direct payments were perceived as complex, requiring the longer term involvement of scarce, skilled and experienced staff, they were not prioritised as 'core business' by some team managers (7.2.1). There appeared to be an absence of both leadership from local politicians and a ground swell of support from the local disabled community (5.2 and 5.3.). This, together with openly expressed objections by powerful interest groups within the authority (7.4 and 7.7.), made operational managers reluctant to take risks. Therefore they referred matters up the chain of command rather than exercising their usual discretion in community-care decision-making. They in turn did not provide support to the strategic and planning managers who were trying to promote the initiative. Senior social services managers did not resolve tensions and conflicts in the local policy-making and implementation process.

4. How did practitioners understand central government policy objectives and what were the influences on their actions in policy implementation?

Practitioners shared the commitment espoused by their political masters, in central and local government, to the values of social justice (policy ends). In 2000 practitioners in Fletcherford were generally in support of New Labour's policy programme (chapter 6). They were persuaded by its proposals to use the market pragmatically (policy theories and means) to achieve value based community care objectives (ends) and to promote 'joined up thinking and action' (policy theories and means). Over the next two years practitioners became disillusioned with the government's approach to policy effectiveness and less convinced that its objectives for modernising social services were based on the same values that underpinned social work practice (chapter 8). In particular, they perceived no improvement in services delivered in the independent sector. Practitioners felt that centralised performance measurement systems were developing into a counter-productive diversion of resource, from making real improvements to cosmetic and short-term service strategies. They were also frustrated by the obstacles to developing and delivering

seamless services to individuals, created by the apparent lack of 'joined up thinking' at the central government policy making level. Individuals' fairly basic needs were still falling into the gaps between health and social care provision. Practitioners remained committed to collective values and service models but were willing to use individualist devices (as distinguished by Priestley 1999) to meet the needs and preferences of users.

Practitioners struggled to achieve community care objectives and to ameliorate the negative effects of the failings of the market. In their interactions with service users they prioritised the latter's interests and preferences over ideological considerations. Practitioners supported 'third way' objectives for individuals and used them in identifying potential benefits of direct payments (table 6.30). However they did not accept the tenets of the risk society thesis of Giddens (1998, 2000) or believe that social problems could be addressed by changing the behaviour and attitudes of individuals. They were not '*small c conservatives*'. As Taylor –Gooby (2000) suggested, '*Blair's scars*' marked resistance to social policy solutions that ignored structural divisions in society. Practitioners reconciled tensions between community care policies and social work and collective values by getting the best they could from the system for individuals, similar to Hoggett's (2001) idea of 'first order agency'. There was therefore some evidence of the counter movement of resistance to 'top-down' social engineering approaches to social intervention that Jordan (2000) described.

There was reciprocity and interdependence between users and carers in both towns. The giving and receiving of 'care' are regular aspects of intimate relationships, including those where one person relies on the physical assistance of a loved one. Caring relationships are about mutual benefit and interdependence. Walmsley (1993) found that it was sometimes impossible to distinguish between the care-giver and cared- for in informal relationships and this was the case in both Fletcherford (8.2.2.) and Bigtown (9.2.3). The 'ideology of caring' postulated Morris (1993) was exposed in national policies (Dept. Health 1998a, 2.22) and local responses. Carers were constructed as a client group rather than co-workers and they were assessed and charged for services. However this construction was manipulated by practitioners, to get improved care arrangements and to break through budget ceilings.

Practitioners clearly had more opportunities to understand users' needs and experiences of service delivery than central contracting staff. However they did not have the authority to exercise market power as the 'agents' of service users in either town. Despite New Labour's professed determination to use markets pragmatically rather than ideologically (Dept. of Health 1998a, DETR 1998) the market weaknesses identified by Le Grand (1993) and Bartlett et al (1998) remained. The

restrictions on the roles of care managers as market actors, revealed by the research discussed earlier (3.1.1.), were evident in both authorities.

The literature reviewed earlier suggested that as 'street level bureaucrats' practitioners are left to resolve tensions in policy making and make the unpalatable decisions their managers and political masters wish to avoid (3.1.2.). There was evidence of this, both in relation to direct payments and in the wider context of community care practice. The research (3.2) also identified the crucial role of care managers as ambassadors and gatekeepers for direct payments. There was no evidence of practitioners consciously putting their personal or professional interests before those of the people they served, nor in the case of direct payments, having an ideologically driven resistance to dealing with finance or consumerist service models. However most acknowledged that they both struggled with the 'system' on a daily basis and were forced to compromise their values to get the work done. They were obliged to ration the time they spent working on behalf of individuals as well as the funds available for services, which meant that all those who needed their help got a share of the inadequate resources. The apparently complicated procedures to be followed meant that arranging direct payments seemed to be a time-consuming and onerous process. These very practical considerations, meant that only the most confident and experienced care managers in both authorities promoted direct payments with individual users and sustained enough enthusiasm to guide them through that process.

The importance of care managers in promoting take up of direct payments (Carmichael and Brown 2002, Dawson 2000) was confirmed and explained within complexity of particular political and historical situations and within a larger policy programme. The SSI's (2000) research found an association between care management staff ambivalence and lack of knowledge with low take up. This study shows how 'ambivalence' developed from an initial enthusiasm but that it was not present at the outset (6.6.).

5. What part did service users/ citizens play in the policy implementation process and how did they understand their participation?

The government led by example in involving disabled people and their organisations in policy development at the national level. The contribution of interest groups to the drafting of guidance and the funding of the N.C.I.L. suggests evidence of the '*clientelistic tendencies in the fragmented state*' identified by Maloney and colleagues (1994). They found that these tendencies allowed some groups representing particular interests to exercise influence, through sharing political and technical knowledge with civil servants. However policy guidance left councils with ultimate discretion in deciding what form participation in the development of local schemes would take.

Arnstein's (1971) theoretical 'ladder of participation' showed symbolically that what passes for user participation can mean considerable variation in the nature and degree to which users have power in decision making. Croft and Beresford's (1993) distinction between two broad models of democratic and consumerist participation was relevant to the alternative approaches of the two councils to 'consultation'. The vagueness of central government direction on the form that user involvement should take in the development of local direct payments schemes (Dept. of Health 2000a, 11:3, 12:7) meant that aspirations in Fletcherford for participation were at the lower rungs of Arnstein's ladder.

New Labour's policy recognised the 'expertise' of users and their potential contribution to the cost effective management of resources and the development of high quality services (DETR 1998, Dept of Health 1998a 2.55). Past experience of consultation gave disabled people in Fletcherford low expectations of their potential involvement in the development of a direct payment scheme, which experiences of the planning process reinforced. Community representatives were unable to exercise any influence over key decisions, which made direct payments less attractive and gradually deterred service users from further involvement in the planning process. Martin and Boaz (2002) asserted that appetites for participation vary between communities and individuals. This case study shows how those appetites may be influenced by past experiences of both the process and the outcomes of 'participation' (7.5).

Users exerted control in individual assessment and care planning processes through their interactions with practitioners (7.6.6., 8.6.7., 9.5), supporting Shaw's (1997) assertion that the participation and involvement of users is often restricted to the 'micro-level' of individual influence on the actions of front line workers. The effective exclusion of users from the design and development of the direct payment scheme and support arrangements in Fletcherford meant that their influence was also kept to the level of Hoggett's (2001) 'first order' agency.

6. Why do some community care service users want to manage their care arrangements through direct payments and how does the implementation process assist or obstruct them in realising their personal objectives?

Users' accounts of their experiences and aspirations suggested that they shared the government's objectives of making community care policy more effective. People interested in direct payments in Fletcherford wanted to counter the impact of the competitive individualism, market weaknesses and resource constraint that had been the outcomes of the Conservative governments' approach. They were also motivated by social justice considerations in their attempts to defend collective services, to protect the conditions of care staff and to apply rationing criteria to their own needs, using no

more public resources than necessary. Because of the lack of clarity and firmness in policy directives, where others wanted to obstruct or diminish the empowering potential of direct payments they could exploit their superior power in the policy 'sub- systems' to do so. For most users, direct payments were second best to good public services and well paid, well trained, trustworthy staff. The availability of a high quality, appropriate, reliable service was more important than an abstract notion of 'choice', as Barnes and Prior (1995) predicted.

Users and practitioners in Fletcherford used direct payments pragmatically, to ameliorate the effects of community care policy on the quality of their service and the lives of care staff. That this would happen was indicated by the 1997 consultation and users' aspirations to protect the 'collective' day provision. Users and practitioners were more committed to the principles of 'partnership' between those who provide and receive services than some senior managers in Fletcherford. There was no evidence in either authority that users saw themselves as 'consumers' of services seeking purchasing power to 'shop around'. Instead they sought mutually satisfying relationships with care staff (8.5 and 9.2.6.2).

Doyal and Gough (1991) postulated that it is possible to develop a 'universalisable' definition of human need. Their definition recognised issues of cultural appropriateness, along with physical survival, and so can be applied in the context of every society's expectation of what is an acceptable standard of living and lifestyle. . The accounts of service users and practitioners, in this study, suggested that the community care contracting arrangements were failing to meet the basic needs of disabled people, for security and dignity (8.5.). Evidence of the costs of 'excessive privatisation' reflected experience revealed by research nationally (Henwood 2001) and was predicted by Dunleavy's (1986) 'bureau shaping' model of the behaviour of senior bureaucrats. There was evidence of 'principal/ agent' conflict in the community care market in Fletcherford (Le Grand and Bartlett 1993), where politicians (5.3.3) and bureaucratic purchasers/contract staff, prioritised cost over quality considerations (6.2.). This explained why some service users were interested in direct payments (8.5.).

7. How does a study of the policy- action process help explain the lack of 'success' of this initiative in engaging most disabled people in the management of their own care arrangements through direct payments?

In the 2000 survey practitioners in Fletcherford predicted that general lack of awareness and uncertainty or fear of change would deter most people from seeking a direct payment (6.5). This was borne out in experience over the next two years (Chapter 8). In both authorities the majority of community care service users relied on practitioners for information about policy changes (8.4. and

9.5.). Practitioners felt that the quality of their work had already been diminished by the 'client processing' demands on their role in the implementation of community care and the loss of the traditional casework relationship. Many were wary of promoting an initiative they feared would imply extra work for themselves, when the demand for care management services exceeded supply. Others tried to promote direct payments but found that their own lack of confidence and knowledge reinforced the 'risk aversion' of most of their clients, who were already in vulnerable and disadvantaged situations (8.6.1.). This evidence of 'risk aversion' amongst service users who already felt dis-empowered by the impact of community care policy on their service arrangements supported the findings of Taylor-Gooby's (2001) research. In Bigtown much more attention was given to publicising the availability of direct payments (9.2.5.) than in Fletcherford where information was another source of power that key actors were reluctant to share (8.6.1.). However in the smaller town, informal networks were stronger and most people who enquired about direct payments heard about them through friends, relatives or voluntary groups rather than official channels (Tables 8.2 to 8.5).

The influence of some powerful officers in Fletcherford, who felt they were being forced by government to introduce direct payments, ensured that onerous conditions were attached to receiving them. (7.7. and 8.6.). Most service users therefore felt that the potential benefits did not merit accepting the extra responsibilities and risks implied. The service users who ultimately found the terms on which they were awarded direct payments acceptable, if not ideal, were those who had 'social' and 'cultural' capital, consistent with Greener's (2002) analysis. This capital included their own professional status or that of close relatives, involvement in a rights focused voluntary group or knowledge and experience of managing staff and budgets. The concepts of 'habitus' and symbolic and cultural capital, discussed by Greener (2002), seemed relevant to the ability of some individuals both to assert their interests and elicit a favourable response from service agencies. This could explain why 'capacity' issues were not an obstacle to direct payments in Bigtown for users with 'professional' carers.

In this study, policy making in action owed much to the efforts and initiative of practitioners and end users in testing the boundaries of local schemes and challenging or circumventing obstacles, as well as to the influence of the national disability rights movement. Unfortunately for the contextual and individual reasons discussed above, it was a minority of users and practitioners who found the reason and resources to adopt this pioneering approach (8.7., tables 8.2 to 8.5, 9.3 and table 9.2).

10.2 The interaction between context and mechanism in policy implementation

Experiences of the introduction of direct payments in two local authorities supported Pawson and Tilley's (1997, 57) assertion that the outcomes of policy interventions depend on the interaction between context and mechanisms in policy implementation. Policy interventions succeed only in as far as they introduce the appropriate ideas and opportunities (mechanisms) to the appropriate political, social and historical conditions (contexts).

In the following table Pawson and Tilley's model (1997) is used to summarise the relationships between contexts, mechanisms and outcomes identified in the two areas.

The following table describes the local history of community care and recent policy developments that provided the context for the introduction of 'ideas and opportunities' offered by direct payments in each of the two local authority areas.

Table 10.1 Contextual conditions

Fletcherford	Bigtown
<p>Local community care market was dominated by poor quality independent sector residential and domiciliary services. Dissatisfaction with independent sector services amongst service users and carers was widespread.</p> <p>Policy changes and contemporary service philosophies had been realised in the closure of several council-run day centres in Fletcherford. The move from 'congregated and segregated' day services provoked resistance and distrust of council decision-makers by those who continued to attend traditional day centres.</p> <p>Local disabled people feared that their services and the jobs of council staff were under threat.</p> <p>Councillors felt the authority had been obliged to withdraw from the provision of long term residential care and the very popular 'home care' service, by financial pressures it had inherited as a 'new unitary'. The perverse incentives in the Conservative governments' community care policy, which favoured the independent sector, had exacerbated the problems of lost economies of scale and competition from private providers offering poor wages and working conditions. Services arranged in the community care market through 'spot purchasing' at fixed standard contract prices kept costs to the council, service quality and wages low.</p> <p>A concentrated, fairly homogenous population, with small 'communities of interest' favouring collective service models.</p> <p>The general perception was that community care policy's objective was to cut costs, undermine the role of public sector and the collective nature of service provision.</p> <p>Policy initiatives that drew on market devices or 'consumerist' service models and language, were regarded with suspicion in the social care community.</p>	<p>Local community care market continued to be dominated by the council's own residential, domiciliary and day services. Council services were seen as the safe, reliable, easily accessible, if inflexible, option.</p> <p>The move from 'congregated and segregated' day services had been realised through the re-development of the councils' services as Resource and Independent Living Centres, with council staff accountable to management committees of service users.</p> <p>Local disabled people were involved in appointments and were recruited as employees as well as volunteers.</p> <p>This large well-established authority, with a long tradition of municipal socialism led by strong Labour councils, had used its monopsonistic purchasing power to control the development of community care locally.</p> <p>The independent sector was used to supplement and complement, rather than compete with, public sector provision, through block contracts with a minimum number of preferred providers. Pre-purchased service units reduced transaction costs and achieved economies of scale for both purchaser and providers, and offered the latter some security to encourage investment.</p> <p>A large, diverse population spread over dense conurbations and rural areas required a range of services accessible in a variety of locations.</p> <p>The council's own services were not seen as flexible enough to respond to every need and community.</p> <p>Policy initiatives, that drew on market devices or 'consumerist' service models and language, were not automatically regarded with suspicion in the social care community.</p>

Councils were given the powers to make direct payments in lieu of community care services by legislation passed by the Major government. The following table contrasts the way that the idea and opportunity (mechanism) offered by the initiative was introduced to the two communities.

Table 10.1.1. Mechanism: Community Care (Direct Payments Act) 1996

Fletcherford	Bigtown
Direct payments were introduced as an 'idea and opportunity' to Fletcherford councillors and senior managers through official department of health channels and so were perceived as a Conservative Government initiative.	Direct payments were introduced as an 'idea and opportunity' to local people through the national networks of the disabled people's organisations.
Direct payments were introduced as an 'idea and opportunity' to local people by senior managers from social services.	Direct payments were introduced as an 'idea and opportunity' to Bigtown councillors and senior managers by local disabled people as an initiative with its roots in the campaigning efforts of the disability rights movement.

The interaction of context and mechanism in the two authorities led to different outcomes, shown in Table 10.1.2.

10.1.2. Outcomes (1a)

Fletcherford	Bigtown
Councillors agreed to a 'low key' consultation by policy and planning officers, which by-passed most potentially eligible users and the practitioners who may have represented their opinions.	Expressions of support from local disabled people convinced councillors that this was an 'empowering' rather than a 'consumerist' service model. In the expectation of significant local interest they commissioned a major independent consultation.
Service users perceived direct payments as a further threat to remaining council services and jobs. The small number of local service users involved therefore responded negatively in the official consultation, while exploring the potential for using direct payments collectively to protect their day centre.	Local disabled people, actively involved in the management of an Independent Living Centre, promoted direct payments. Local community care users responded positively to the major consultation. The consultation report recommended the introduction of a direct payment scheme and a well-resourced support service.
Fletcherford councillors were relieved to have their assumptions confirmed; that local people would not be interested in another 'Tory' initiative intended to further privatise services and responsibilities.	Bigtown councillors expected that local people would be interested in and support the development of direct payments.
The council decided not to use its new powers to make direct payments.	The council decided to use its new powers to make direct payments.

New Labour adopted direct payments and made their extension and promotion a new policy initiative that local authorities were obliged to implement. They did this in the context of their wider programme for modernising social services and centrally managed performance. In Fletcherford, direct payments were perceived by councillors as yet another initiative imposed by central government. In Bigtown, direct payments were perceived as a potential means of empowerment for disabled people. The following tables (10.1.3 and 10.1.4.) contrast the way the different contextual conditions (shown in Table 10.1) interacted with the 'idea and opportunity' offered by direct payments, to affect the way that the implementation of direct payments was planned in each authority.

Table 10.1.3. Planning the introduction of direct payments

Fletcherford	Bigtown
When Fletcherford council and senior officers were obliged to introduce direct payments, by New Labour policy, they did this both in the expectation of little local interest and with procedures that made arranging and managing a direct payment complicated and onerous.	The council delegated authority (power and responsibilities) to a working group of senior officers with a range of technical expertise and experience of community care and local users.
Senior managers who supported direct payments moved to other roles in the 'modernisation' programme. Operational managers, overloaded with wider implementation and performance management responsibilities, were not involved in the development of the scheme.	The working group members remained in post throughout the development of the local scheme to support and advise team managers and practitioners involved in implementation. They were empowered to change the scheme in response to the demands and experiences of local people.

Differences in the approach taken to developing direct payments in each of the two authorities, had implications for outcomes in terms of the design and ongoing development of each scheme.

10.1.4. Outcomes (1b)

Fletcherford	Bigtown
Planning managers were left unsupported in the face of obstruction from corporate colleagues exercising disproportionate power through symbolic, cultural and political capital (professional status, technical knowledge or influence over inexperienced politicians). Team managers did not feel empowered to exercise discretion or allow flexibility in implementation in response to obstacles identified by users and practitioners. Direct payments were denied to users who could not demonstrate their 'capacity' despite the conflict with other policy initiatives, like 'Valuing People'.	Payment rates and systems and monitoring procedures were all designed with a view to making direct payments easy for users to understand and manage. Practice pre-empted policy in Bigtown, with the local scheme reflecting the spirit of the legislation (policy ends) rather than the letter of the law (policy means). Direct payments were made to individuals, where 'capacity' was potentially an issue, before the New Labour guidance (Dept. of Health 2000a) relaxed the 'able and willing' test.

The alternative approaches taken to developing capacity in the local community, working with the voluntary sector and providing support for direct payment users proved to be significant in the way the support service for direct payment users developed in each of the authorities as the following tables show (10.2.1. to 10.2.3.).

10.2.1. Context : the relationship between the council and the voluntary sector

Fletcherford	The context was one where there was no practice of capacity building in communities and individuals. Funding and relationships between the social services department and the voluntary sector were through contract only that is market transactions rather than partnerships. There was no expectation local people would be interested in developing a service.	Bigtown The context was one where there was a tradition of involvement of local disabled people in the development and management of services. There was an expectation of interest in direct payments and that local disabled people would want to be involved in developing and providing support to direct payment users.
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10.2.2. Mechanism : the decision to provide a support service

Fletcherford	The 'idea and opportunity' to provide a support service for direct payment users was introduced to Fletcherford council by government guidance (Dept of Health 2000).	Bigtown The 'idea and opportunity' to provide a support service for direct payment users was introduced to Bigtown council by the independent consultation with local community care users.
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10.2.3. Outcomes (2)

Fletcherford	<p>Individuals and local groups were invited to join planning group but given no delegated responsibilities or powers.</p> <p>Council contracted with a support service from another area to save time (because of pressures to demonstrate 'performance' in the achievement of centrally set objectives) and money (in response to perceived 'top-down' pressure rather than in recognition of local 'bottom-up' demands).</p> <p>The 'independent' support service, introduced without the involvement of local people, lacked the support of local user and voluntary sector networks. It relied on senior council managers for continuing annual funding. It was unable to challenge council decisions on behalf of users. Pressure to demonstrate 'performance' in pursuit of number 'targets', and the cost and volume contract, led to attempts by the manager to 'cream skim' (Le Grand et al 1993) least costly users.</p>	<p>Bigtown</p> <p>The council decided to provide the support service directly through the highly credible Centre for Independent Living which was well established in local networks. Support service staff appointed by and accountable to the users' management committee.</p> <p>Secure direct funding, permanent contracts, the support of local users and politicians empowered staff to advocate on behalf of individuals, to challenge decision making and influence the development of the direct payment scheme;</p> <p>The well- resourced direct payment scheme and support service facilitated publicity and promotion of take up of direct payments and quick responses to user enquiries and concerns. There was no incentive in funding arrangements to favour 'easier' /less costly users. Users with complex needs and with potentially impaired capacity, were enabled to use direct payments.</p>
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Practitioners in Fletcherford (chapter 6) predicted that knowledge about the availability and potential of direct payments would be crucial to the progress of the introduction of direct payments. They also suggested that most users would wait to see examples of success before deciding to opt out of direct services. The importance of anecdotal 'publicity' was confirmed by experiences of implementation in both towns, as tables 10.3.1. to 10.3.3. show.

Table 10.3.1. Context : the community care 'grapevine' (informal networks of communication)

Fletcherford	Bigtown
A small town with close knit communities and stable population.	A large town with distinct communities and services spread over several 'patches'.
Disabled people and carers used single resource centres and practitioners shared single office bases	Specialist practitioner teams located in separate areas and office bases.

Geographic, demographic and organisational features of the local context influenced the way in which information about direct payments (mechanism) spread amongst service users and practitioners in each local authority:

Table 10.3.2. Mechanism : knowledge about direct payments

Fletcherford	Bigtown
There was frequent contact between practitioners and strong, informal networks of communication amongst people who used services.	There was limited contact between service users from different areas and practitioners from different specialisms and localities.
The majority of interested users and practitioners chose to observe the experiences of others attempting to access direct payments.	Few opportunities to learn from others' positive experiences + lack of general consciousness of the potential of direct payments amongst practitioners.

Although Bigtown council invested far more resources in publicising and promoting direct payments, the interaction between contextual conditions and informal communication had a significant impact on the general level of awareness in the two communities :

Table 10.3.3. Outcomes (3)

Fletcherford	Bigtown
Negative accounts spread more quickly than the official publicity for the scheme.	Awareness spread slowly beyond a small number of well-informed disabled people

The organisational context for care management in both towns was one where demand was increasing, practice was continually developing in response to policy and demographic changes and there were staff shortages.

Table 10.4.1. Context : the organisational situation and work load of care managers

Fletcherford	Bigtown
Over worked and often inexperienced practitioners were under pressure to achieve 'turnover' in assessments, while reconciling often contradictory 'modernising' objectives.	Over worked and frequently inexperienced practitioners were under pressure to achieve 'turnover' in assessments, while reconciling often contradictory 'modernising' objectives

Procedures for arranging direct payments changed in both authorities. In Fletcherford this was in response to the concerns of senior managers and in Bigtown this was in response to the experiences of practitioners and users involved in arranging direct payments.

Table 10.4.2. Mechanism : the introduction of direct payments as an 'idea and opportunity' for care management

Fletcherford	Bigtown
When direct payments were introduced they were seen as complicated and time consuming and were therefore not promoted by most practitioners, who could not respond to users' enquiries with confidence and clarity.	As the scheme became established, direct payments were seen as complicated and time consuming and were therefore not promoted by most practitioners, who despite training and support from senior practitioners did not keep up to date with developments in the local scheme.

Despite the differences in the investment in training and supporting practitioners in the two authorities, the interaction of context and mechanism produced similar outcomes.

Table 10.4.3. Outcomes (4)

Fletcherford	Bigtown
Only the most confident and experienced practitioners encouraged disabled people to request direct payment and sustained the enthusiasm to support them through the process. They did so by circumventing obstacles in both the procedures for arranging direct payments and community care eligibility criteria and budget ceilings.	Only the most confident and experienced practitioners encouraged disabled people to request direct payment. They did so by familiarising themselves with the local scheme and circumventing community care eligibility criteria and budget ceilings in the users' interests
Practitioners, who exercised discretion in manipulating policy 'means' to achieve policy 'ends', contributed to policy-making through implementation.	Practitioners, who exercised discretion in manipulating policy 'means' to achieve policy 'ends', contributed to policy-making through implementation

Community care users' expectations of direct payments were influenced by their past experiences of local community care arrangements and policy change.

10.5.1. Context: service users' experiences of community care

Fletcherford	Bigtown
Past experience of community care led users to expect policy changes to reduce the quality and quantity of services and contributed to the 'risk-aversion' of most community care users, carers and front line workers.	Past experience of community care led users to regard the council's own services as offering safe, reliable, if inflexible, care packages provided by trustworthy, competent staff.

The introduction of direct payments as a selective service model, within the context of community care legislation, meant that although councils were obliged to offer direct payments they could apply their own eligibility criteria, set payment rates and attach conditions to their use. Characteristics of the schemes introduced by both councils made direct payments unattractive to many users.

10.5.2. Mechanism :Local policies, procedures and eligibility criteria

Fletcherford	Bigtown
Despite widespread dissatisfaction with independent sector domiciliary care, most who enquired about direct payments decided not to take the risk of changing their care arrangements.	Despite some users' dissatisfaction with inflexibilities in council services, most who enquired about direct payments decided not to take the risk of changing their care arrangements.
They were deterred not only by complicated procedures but by worries about extra responsibilities, particularly arranging cover in emergencies.	They were not deterred by complicated procedures but by worries about extra responsibilities, in particular arranging cover in emergencies.

Despite some significant differences in the experiences, expectations and implementation of community care and direct payments (shown in tables 10.5.1. and 10.5.2.), the interaction between context and mechanism led to similar outcomes in the two authorities. 'Capital' was not equally distributed amongst the service user population in either town. Individual 'habitus' and personal 'capital' influenced who ultimately received direct payments.

10.5.3. Outcomes (5)

Fletcherford	Bigtown
A minority of users ultimately received direct payments. Those who did wanted a relationship with a reliable, competent person they knew and trusted and to improve on the wages and conditions offered to staff by private agencies.	A minority of users ultimately received direct payments. Those who did wanted a relationship with a reliable, competent person they knew and trusted and to overcome the inflexibilities imposed on council staff and users by management.
Habitus and access to various forms of capital: social (networks), symbolic (status), economic (personal resources) or cultural (knowledge of the system) proved significant to their success in achieving the personal outcomes they sought.	Habitus and access to various forms of capital: social (networks), symbolic (status), or cultural (knowledge of the system) proved significant to their success in achieving the personal outcomes they sought.

10.2.1. Key Similarities and Differences between Fletcherford and Bigtown

There was an apparent political commitment to collectivist values and services in Bigtown, where the independent sector supplemented rather than competed with public services. Nevertheless Bigtown was a more receptive context, politically, to the ideas and opportunities presented by direct payments, because support for the initiative seemed to come from local people as well central government. A core group of active, well informed disabled people had heard about direct payments, through their national organizations, and recognized their empowering potential. The community-care 'culture' however, characterised by the values, attitudes and expectations of most users and practitioners, was less receptive than in Fletcherford. In Bigtown council services were generally perceived as the safe, straightforward option for practitioners and users, whereas direct payments implied more responsibilities and greater risk. In Bigtown a minority of those service users who were aware of direct payments and expressed an interest in them, ultimately decided to accept cash instead of services. Those who did were motivated by a desire to secure a relationship with particular individuals and by frustration with inflexible local authority management practices (9.2.6.). In Bigtown, practitioners and users contributed to policy development in practice, by both the exercise of discretion and by communicating their concerns and suggestions for improving the scheme to senior decision makers in the council.

In contrast, in Fletcherford, private agencies dominated local social care provision. Past experience of community-care and policy change meant that users expected that the implementation of initiatives would have a detrimental effect on their care arrangements. They suspected the motives of senior managers from social services when the possibility of further policy change was introduced. Lack of active support from councillors, who perceived little interest in direct payments from users, and lack of real involvement of local people in the planning and development of the Fletcherford scheme, meant that officers opposed to their introduction could make arranging and managing direct payments unnecessarily onerous. Despite widespread dissatisfaction with the quality of the independent sector services, the personal experiences and situation of most service users in Fletcherford made them 'risk-averse'. They were deterred from direct payments by both complicated procedures and concerns about taking on more responsibilities. A minority ultimately received direct payments in Fletcherford. They did so to secure a relationship with someone they trusted as competent and reliable, to improve the wages and working conditions of the latter and to improve the flexibility of their care arrangements to suit them both (8.5). In Fletcherford, practitioners and users contributed to policy development in practice through the exercise of discretion and the subversion and manipulation of rules and procedures. Bourdieu's concepts of 'habitus' and 'capital', discussed by Greener (2002), proved relevant to the differential access and attitudes of disabled people to direct payments in both areas.

The findings summarised in Tables 10.1 to 10.5.3. demonstrate that the New Labour government's attempt to achieve policy effectiveness was limited by its failure to take into account the effect of past experience, political values and expectations on policy actors' responses to the ideas and opportunities offered by the initiative. Its approach neglected the ideological, psychological and social dimensions of organisational, professional and community cultures and also the attitude to risk and participation of individual service users based on their personal histories, circumstances and resources. The government's approach also failed to resolve the practical problems in including this initiative in a whole programme of policy reform delegated to councils, already beleaguered by staff shortages.

10.3. Lessons from the direct payments case study in policy action

10.3.1 Policy making during implementation

Issues identified as obstacles to the successful extension of direct payments in Fletcherford between 2000 and 2002 were addressed by changes in central government guidance (Dept of Health, 2002a). Developments in policy making during implementation suggested that experiences in Fletcherford were not unusual. The increasing firmness of central government directives, 'top down' pressure, reflected the influence of 'bottom up' demands for change, from local and national citizen/user groups who identified blocks to progress. This supported Sabatier's (1986) contention that policy studies should combine both 'top down' and 'bottom up' analyses.

It was not possible to distinguish the policy making from the implementation process as policy continued to develop through the policy action 'chain'. However the government's responses to developments in practice were always contained within the parameters of the prevailing policy framework and an individualist model of direct payments. Policy developments heralded included: guidance on 'indirect payments' to resolve capacity issues; the requirement that direct payments match the usual cost of arranging services; the rescinding of the power of individual councils to determine which services could be converted to cash; extra funding for support services and the power to make direct payments for joint health and social care packages (Dept of Health, 2002a). Developments in national policy were intended to overcome the reluctance of councils to give disabled people a genuine choice about whether to opt out of direct services (Introduction to draft consultation, Dept of Health, 2002a). However uncertainty, frustration and conflict over these issues provided negative experiences for users, carers and practitioners in Fletcherford, which experience in Bigtown suggested, would leave a lasting impression on the service community. This illustrated how the efforts of actors responsible for providing guidance on implementation, to allow opportunities for lower level actors to develop policy in response to local needs and conditions (mechanisms) had mixed outcomes in particular contexts.

10.3.2. The significance of context

The **historical and political contexts and the local community cultures** proved relevant. The principle of giving disabled people budgets to make their own care arrangements seems no more radical than giving people reliant on state benefits cash to buy their own food. However the split between income replacement benefits and services in kind, created by the 1948 National Assistance Act, meant that the recognition of user insight and expertise implied by direct payments threatened the power base and 'authority' of bureaucratic experts in local authorities. There were officers in Fletcherford who wanted to minimise the impact of direct payments. This may have been simply to protect their own vested interests as 'experts', because they believed that collective resources should remain in collective services, or because they were not persuaded that community-care users were capable of managing budgets and staff. Whether for any or all of these reasons, some officers colluded to make direct payments unappealing to most individuals using services. The influence of a '*care discourse*' (Morris 1993), suspicion of the motives of service users and providers (Le Grand 1997) and differences in the '*habitus*' of individuals (Greener 2000) were all evident in these attempts to limit the impact and effectiveness of direct payments. Lack of strong leadership from councillors in Fletcherford meant that those who resisted or embraced direct payments did so without political surveillance or interference. Experience of community-care and the impact of past policy change affected expectations of and attitudes to direct payments in both local communities.

The **organisational context and professional culture** for implementation through local authority social services influenced the progress of this initiative. Most social work practitioners and team managers recognised the potential benefits for users of direct payments. Their professional values supported the principle of self-determination from which the policy had developed in the disability rights movement. Their activities and motivation in care management generally fitted Barron's (2001) model of 'professional support' focused on empowering rather than controlling welfare 'subjects'. They were keen to share power with service users, just as users expressing an interest in direct payments wanted to share power with, rather than wield power over, their staff. In implementing community-care policy, practitioners assessed and interpreted users' needs to circumvent local eligibility criteria and budget constraints. In implementing direct payments, they re-interpreted local policies and procedures to meet users' needs and preferences. They were unofficially empowered to do this by senior managers who had risen up through the social work ranks and chose to 'look the other way' when practitioners were manipulating the rules (policy means) to achieve positive outcomes (policy ends). Their efforts provided evidence of the exercise of power in policy action by 'street level bureaucrats' (Lipsky 1980, Hudson 1989, Myers and McDonald 1996, Wells 1997) and what Bradley (2000) called 'administrative justice'.

Conflict between the Conservative government's 'New Public Management' and social work values identified by Flynn (1999) continued in New Labour's 'modern management' approach as Newman (2000) suggested. Practitioners became increasingly disillusioned with central government strategies (policy theories and means) but supported the official objectives (policy ends) and independent living principles. They resolved tensions between professional values and personal interests by 'covert' subversion. Practitioners thus resolved the classical dilemma that has always faced social work in Jordan's (2000) analysis, between reformism and resistance. In this regard, the motivation of practitioners was more *knightly* than *knave-like* (Le Grand 1997, Taylor-Gooby 2002). This was despite their experience of government's attempts to control their behaviour, discussed by Jordan (2000), and the experience of role conflict identified by Brandon and Brandon (2002). Practitioners were very aware of the *discourse of failure*, described by Langan (2000), shrouding the work of personal social services and the stigma associated with residual services. However they rejected both, along with the individualisation of social problems in New Labour's policies, identified by Lister (1998).

10.3.3. The use of 'modern means' or mechanisms

Failings in the government's approach to policy effectiveness were revealed in the four areas identified in its policy statements and documents: 'joined-up' thinking and action; 'third way' pragmatism; participation and centralised performance management. Problems in implementation arose from conflict between objectives, or an apparent lack of 'joined-up thinking'. Pragmatism met ideological resistance amongst those who held power in local authorities and tensions between collectivist and individualist values were evident at the national level. Participation without any tradition of capacity building and power sharing meant little more than tokenistic consultation in Fletcherford. Performance management systems led to the manipulation of crude output measures, so that the 'means' promoted to increase empowerment, introducing local direct payment schemes, were substituted for the 'ends' of giving users choice and control in service strategies and their own care arrangements. '*Street level bureaucrats*' were left to fill the gaps and reconcile the conflicts through their interactions with and actions on behalf of individual citizens.

When the state and its many vested interests give power with one hand it appears to take it away with the other. For example, the extension of direct payments gave less than 8000 disabled people direct purchasing power to arrange their own care during the case study period. At the same time the 'Supporting People' initiative wrested direct purchasing power from almost 800,000 tenants of supported housing, including community-care users, and passed it back to local authority purchasers (Office of the Deputy Prime Minister, 2003). Social services staff had a key role in implementing both these initiatives between 2000 and 2002. Tensions in New Labour's wider programme, masked by its 'modernising' language, were thus revealed in its

ambivalent and inconsistent application of market theory, in different policy and service contexts.

10.4. Conclusions

The new guidance and legislation on direct payments, to become effective in 2003, would address some of the obstacles identified in this case study. However those changes occurred in response to progress and problems in implementation, supporting Lindblom's (1959) '*muddling through*' account of the policy action process. The case study demonstrated how motivation, values and beliefs of individual actors should not be assumed outside of the context of their own experiences and social situations. Models of human behaviour based on an assumption of instrumental rationality and the 'risk society' thesis of Giddens (1998) proved to be inadequate to the complexity of the policy problem, as predicted by the work of Greener (2002), Hoggett (2001), Martin and Boaz (2000) and Taylor-Gooby (1999, 2001).

The importance of the role of practitioners in developing policy through implementation, based on their knowledge of the needs and preferences of individuals in their particular social situations, was also illustrated. It is at the level of practitioner- citizen relationships that most community- care users participate in the decision-making that affects their lives, as the work of Lipsky (1980) and Shaw (1997) suggested. This means, however, that the experiences of many individual users are subject to the situation, skill and motivation of individual practitioners as well as their own circumstances or characteristics. These are issues that performance management tools, focusing on local accountability for aggregate numbers and outcome targets, are too blunt to address. In the policy context of community-care, central government will only achieve the objective of 'promoting independence' through extending choice and control to most service users, in as far as, and when and where, it succeeds in engaging and empowering people at the level of citizen-practitioner interaction.

Social work has always lived with the 'classical dilemma' identified by Jordan (2000) between reformism and resistance. Social workers as care managers are left to make unpalatable decisions on matters of social justice that policy makers seem unwilling or unable to address. These include the rationing of scarce resources amongst the many legitimate demands on public funds (gate keeping) and challenging the distribution of power and decision making authority in the face of opposition from those with vested interests in the status quo (advocacy).

Practitioners will continue to have that crucial role in the implementation and continuing development of policy while particular initiatives are contained within the parameters of community-care policy and based on the selective/ residual model of welfare on which the personal social services were founded. They require recognition and resources, in terms of time, support and training, to carry out that role effectively.

That direct payments ever became a national policy issue was a great achievement of the disabled people's rights movement, but that achievement was tempered by implementation responsibilities being delegated to local authorities within their responsibilities for community-care. The Blair government used its policy programme to communicate its vision: of ethics (rights and responsibilities), economic efficiency and social cohesion. It was determined to bridge the 'implementation gap' (Dunsire 1976, Dept of Health 1998a). However it was constrained by history: the legacy of the 19th century Poor Law, the division between universal and selective welfare institutionalised in the 1948 legislation, as well as the changed landscape left by the Conservative government's reforms. New Labour's convictions about what the electorate would not countenance also limited the policy choices it perceived were available, in particular income tax increases and any evidence of intentions to 'privatise' health care. The government's response to the latter was not just a matter of political expediency or populism. The privileging of the National Health Service as a 'collective good' extended from the minister to practitioners and users. In practice, however health and social care have been re-defined by politicians, public service managers, practitioners and citizens alike to achieve desired objectives.

The case study illustrated the complexity of the policy- action process and the many and varied influences on the progress and outcomes of particular initiatives. It looked inside the 'black box' of implementation to examine how policy initiatives can in some circumstances achieve their identified outcomes, but in others have unintended or counter-productive consequences. Therefore, as Pawson and Tilley (1997) asserted, evaluations of policy changes should look further than outcomes and include an investigation of how far the working of such mechanisms are contingent and conditional.

The continuing relevance of Lindblom and Woodhouse's (1993, 10) description of policy development: *'with action occurring fitfully as problems become matched with policy ideas considered to be in the political interests of a working majority of partisans with influence over the policy domain'* was illustrated. However the influence of morality, values and ideological conviction on human agency was also confirmed. The case study followed the process through the actions and intentions of the multiplicity of policy actors involved in the development of a particular initiative. It demonstrated problems with New Labour's approach to implementation in seeking compliance with its policy programme through centralised performance management systems, focusing on narrowly defined intermediate objectives to the detriment of ultimate policy goals. Pragmatism based on 'what works' will not guarantee success if it does not specify **how** particular initiatives work. Attempts to generalise from the 'success' of particular initiatives will not necessarily achieve the intended outcomes if the relevance of contextual

conditions - history, politics, organisational, professional and community cultures are not addressed.

10.5 Contribution

My study was original in its approach to researching the social policy implementation process, through using a case study of one initiative to explore the actions, motivations, convictions and theories of actors at each link in the policy action chain. Its contribution to knowledge is at three levels.

10.5.1. Policy Studies

The work confirms that policy action is a complex, non-linear process and supports a generative model of causation. In exploring the policy action process, my key source was Pawson and Tilley (1997). They argued that policy research should not simply examine whether or not the objectives of particular initiatives are achieved but recognise that policy programmes are embedded within a wider set of 'macro' and 'micro' forces. I followed their advice that the researcher should investigate the implementation process to explore how the ideas and opportunities offered by initiatives interact with the conditions of the local environment, and the experiences and expectations of policy actors, who have 'powers and liabilities' which allow them to accept or resist change. I used Pawson and Tilley's framework, of *context + mechanism + outcome*, to analyse and present my findings (tables 10.1. to 10.5.3.). I also drew on Sanderson's (2000) insights into the *cumulative impact of policy change* in exploring the interaction between context and mechanism in each area.

10.5.2. Social Policy

Social policies and welfare strategies are based on theories about human behaviour and motivation. My contribution to the literature is to demonstrate that welfare actors are not simply instrumentally motivated. They act on the basis of values and convictions, as well as perceived personal interests, and they are concerned with social justice. Taylor-Gooby's (1999, 2000 and 2001) critique of New Labour's assumptions about the motivation and behaviour of welfare actors (service providers and users) provided the foundation for my exploration of the concept of 'agency' and its relevance to social policy.

10.5.3. New Labour's Social Policy and its Approach to Implementation

My key source here was Driver and Martell (1998). Their work provided the framework for my review of the various critiques of recent policy developments and New Labour's programme of proposed reforms. The *Who, How and Why?* questions enabled me to analyse the theoretical reasoning on which the assumptions underpinning New Labour's policies were based. By exploring New Labour's approach through a case study of a 'third way' initiative, I demonstrated that the modernising programme does not combine economic and social

objectives as was claimed (Blair, 1996). Instead, the tensions between them, that previous Labour government's struggled to reconcile, are disguised by a modernising discourse. Newman's (2001) critique of New Labour's efforts to establish its own dominant narrative, through new political ideas and representations of society, was the major source for my analysis of the use and appropriation of 'modernising discourse' by policy actors. My thesis reveals how welfare actors did, in practice, use New Labour language and concepts to guide and explain the decisions they made, and to justify their prioritising of contradictory policy objectives. Examples of the alternative, often contradictory meanings of New Labour language in this case study included: '*independence*' (self sufficiency or self determination); '*choice*' (as a means or an end, as consumerism or empowerment); '*fairness*'/ '*social justice*' (equality of opportunity or outcome); '*inclusion*' (relational or economic); '*contributions/ citizenship duties*' (recognising public/ community/ military service or current employment only); '*partnership*' (co-ordinated planning and service delivery or the covert but gradual erosion of collective values and service models and the 'privatisation' of welfare through the move from universal to selective provision) and '*participation*' (citizen control/ delegated power or tokenistic consultation and manipulation).

My work showed that policy actors do not act on the basis of perceived self interest alone, nor do they all fit the model of the reflexive actor as subject, on which the 'risk society' thesis and the third way ideal of the active citizen seems to depend. People make decisions and act on the basis of the choices they believe are available, from politicians to practitioners and service users. I also highlighted how access to and control over various forms of capital was crucial to the exercise of choice and self-determination by welfare actors. I confirmed the significance the various forms of capital identified by Greener (2001) in the social policy field. They were symbolic (status), political (power and influence over decision-makers), cultural (knowledge) and economic (control over budgets and personal resources). I also found that 'social capital' was crucial to individual welfare subjects. Service users who were involved in community or voluntary sector networks, or who had relatives or friends working in the community-care field, were most likely to realise their own objectives (ends) from policy changes.

Finally, my contribution has been to reveal how New Labour's approach to securing policy effectiveness has often been counter-productive. The use of centralised performance management techniques led to a narrow focus on crude performance measures, a short-term perspective in planning and decision-making and the displacement of policy ends by policy means. In its efforts to 'modernise' community-care services, central government 'overloaded' council leaders, managers and practitioners with initiatives and implementation responsibilities. The consequence has been that the ultimate objectives of policy change have often been obscured, or lost altogether, in the quantity and confusion of implementation imperatives.

Appendix 1

Survey of Practitioners 2000 : Interview Schedule

1. Personal information

Name

Team

Current role

Background / Experience

2. Have you heard of direct payments, if so how?

3. Can you see any potential benefits from the introduction of direct payments in this town ?

4. What would worry you about direct payments?

5. Do you know anybody who might benefit from direct payments?

6. Have any of your clients expressed an interest in direct payments?

7. Why do you think there has been a slow take up of direct payments?

8. Are there any particular issues need to be taken into account in this town?

Opinion Statements

1. Direct payments are about giving money to people and leaving them to get on with it. *
2. Direct payments are about giving users control over the services they get.
3. Direct payments are about enabling users to become employers. *
4. Direct payments have come from a policy of the last Conservative government. *
5. Direct payments are about turning clients into consumers.
6. I have known people who would have benefited from direct payments.
7. Direct payments are not very different from other schemes that have been around for years.
8. Many service users would be worried about the responsibility of getting a direct payment. **
9. Third party schemes employing personal assistants on behalf of service users would do the same as direct payments. *
10. People in this town won't be interested in direct payments. *
11. Direct payments will probably be best for younger people. **
12. Direct payments are for people who are dissatisfied with the services we offer. **
13. Direct payments should be about people getting together to run their own services.
14. Service users might use direct payments for the wrong things. *
15. Direct payments are a threat to in house services.
16. People who get direct payments will probably use agencies.
17. Most people will need a lot of support if they are going to get direct payments.
18. Direct payments could mean a lot of work for social workers.
19. People should get direct payments through the normal assessment processes.
20. There's a risk that people will be exploited if they are given the money to buy their own care. *
21. If our services were good enough people would not want direct payments. *
22. There are other ways of empowering users without giving them cash.
23. People should be able to use direct payments for more than just personal care.
24. People already have a lot of choice over services in this town
25. People should be allowed to use direct payments to buy community health services.
26. If I needed community-care services I would want a direct payment.

27. There's not enough money to pay for all the services people want. Direct payments mean users must decide what to do without

28. Direct payments will only work for people who do not need a lot of care. **

29. Its difficult to get good care staff in this town

30. Direct payments could have a big impact on community-care in this town in the future

31. We are only talking about introducing direct payments in this town because the government says we must.

32. People in this town are generally happy with the services on offer

33. The cash to buy their own care is what users have wanted for years

34. For me, direct payments are about ...

* Statements are quotes from politicians, senior managers and professional adviser during discussions about direct payments in Fletcherford between February and April 2000.

** Statements are taken from the records of the 1997 consultation.

Appendix 2 : Interview Guides

2a. Interview Guide SSI Business Link

Role of the SSI and business link

North East authorities and Direct Payments

New Labour government and direct payments

Performance Assessment

Learning Disability White Paper.

Issues and obstacles

The development of community-care policy and practice.

**The particular experience of Fletcherford : reasons for resistance,
What will help, what will hinder?**

Take up and Third Party Schemes

Contrast New Labour and Tory approaches

Health and Social Care, Health and Continuing Care issues

Pooled budgets and integration

Health Act flexibilities

Costs and ceilings

Charges

Eligibility criteria

Assessment

Universal versus selective service models, implications in practice

Accountability

Other implementation issues

New Labour Government and the market

Control and empowerment

Different sorts of people

Collective models ,

Support schemes

Relationship between direct payments and other policy initiatives :Supporting People,

Best Value

Worries and concerns, outstanding issues and obstacles to expansion

2b. Interview guide NCIL

The history of the NCIL? Relationship with governments.

Relationship with the development of direct payments?

Role and contribution of the disability rights movement?

Role and attitude of politicians. Who were the key people, what has their contribution been?

Tory versus New Labour approach, any differences?

Why the early restrictions (18 to 65)?

What the government could do to help more?

User Involvement? Levels and types. Outcomes and Obstacles

Support schemes .

Role of Care managers?

Experience and views on Monitoring

Experience and views on Ceilings

Health and integration issues

Liability, Health and Safety and Oppression

Centralised Performance Management

Charging

Information.

Guidance from central government

Control and empowerment [including role of council solicitors]

Agencies v Direct Payments

ILF

Self assessment

Eligibility criteria

The role and responsibilities of users as employers

Recruitment of personal assistants [pay, conditions, relationships et cetera]

Collective versus individual control

Seminars with local authorities in the North East

Capacity and 'suitability'

Carers' Direct Payments

Direct Payments for children

2c. Interview guide themes for John Hutton

Government's policy on direct payments and implementation approach

Why did you decide to promote and extend direct payments? [Relationship with wider policy programme].

Why has the govt taken the approach to implementation it has, very gradual policy development towards obliging councils to provide direct payments and still lots of areas for local discretion?

Local authorities have to provide direct payments now but it's down to them to decide and individual cases and there's no obligation to provide a support service or to involve users in the scheme. So it varies between authorities. What do you think about that?

What do you think the obstacles were before the changes in guidance?

What has the government done to remove them?

Why do you think there has not been the take up?

Why the variation?

What would be your criteria for judging the success of the government's policy on direct payments?

How would you assess the performance in implementation of individual local authorities?

Health and Social Care Issues

Do you think that people should eventually be able to get direct payments for community health services? [Examples of problems in individual packages for comment]

What do you think about the issue in the wider policy context of working towards pooled budgets and arguments around responsibilities for individuals.]

I know you have a particular interest in people with learning disabilities, there's been a lot more co-operation between health and social services on funding community packages, than for other groups. What do you think about that?

How is the issue about two tier services with health, different from the argument people make against people getting direct payments for social care? [It's not fair if some people end up better off, with better 'outcomes']

Capacity and consent

Issues of capacity and consent for people with dementia, people in terminal stages of motor neurone disease, Huntingdon's disease, but particularly for people with learning disabilities. You've been active yourself involving people with learning disabilities in your Valuing People Advisory group. What do you think?

Practitioners are running in to capacity and consent issues within their own authorities [hence variation in take up of some groups]. Do you have any ideas as to how these issues can be resolved, to avoid excluding some people in some council areas?

Equity

Fair Access to Care Guidance. What do you hope to achieve?

Equality of opportunity or outcomes?

2d Interview Guide Department of health lead officers

History of direct payments as a policy initiative under New Labour.

How and why?

Background to Roles in department of health and development of direct payments

Third Party Schemes?

Employment issues and self-employment

ILF

Charges

Costs and ceilings

Carers

NCIL and the role of the disability rights movement

User involvement, expectations and experience

Seminars to promote direct payments in the North

Monitoring Performance of Local Authorities

Health and social care issues

Funding

Guidance from government

Capacity and consent

Support schemes

Dumping and discrimination, suitable and unsuitable clients

Best Value

Fair Access

The relationship between direct payments and the wider policy programme

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